



FH Medic User's Guide

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Introduction

FH® Medic, a powerful cloud-based, electronic patient care reporting (ePCR) system, is engineered to meet the needs of emergency medical service (EMS) organizations nationwide from large-scale agencies to the smallest, most basic services. FH Medic is gold-compliance certified by the National EMS Information System (NEMSIS). The *FH® Medic User's Guide* is designed to help you record crew member, response, and patient data on the incident scene, to generate reports and forms from the data entered, and to send the necessary information to the appropriate individuals and facilities.

Caution: The *FH® Medic User's Guide* documents FH Medic with its default display settings and field labels. If an FH Medic administrator uses the FH Medic administration web site to hide fields or change field labels, not all the fields referenced in this *User's Guide* may be available to you. Contact your FH Medic administrator about possible changes if you are not able to find fields referenced in the *User's Guide*.

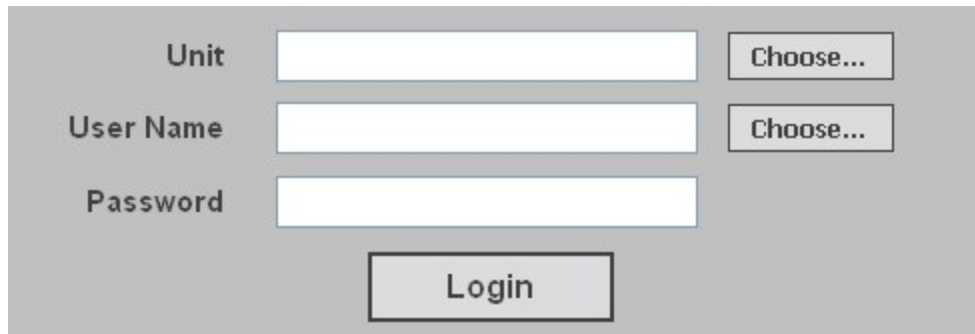
FH® technical support staff is available to answer your questions by telephone or email. Technical support hours are from 7:00 A.M. to 7:00 P.M. Central time, Monday through Friday, and from 8:00 A.M. to 12:00 P.M. on Saturday. Call 800-921-5300, option 2. You can also send an email to support@firehousesoftware.com.

Log into FH Medic

1. Depending on whether you installed a demonstration copy of FH Medic or a purchased copy, do one of the following.

To launch this	Do this
Demonstration copy	• Choose Start → Xerox → FH Medic → FH Medic .
Purchased copy	• Choose Start → ACS Inc → FH Medic → FH Medic .

The FH Medic login screen appears.

The login screen has a light gray background. On the left, the labels 'Unit', 'User Name', and 'Password' are stacked vertically. To the right of each label is a white text input field. To the right of the 'Unit' and 'User Name' fields are small gray buttons with the text 'Choose...'. Below the 'Password' field is a larger gray button with the text 'Login'.

2. Click in **Unit**, or click **Choose** to the right of **Unit**.

The **Select Unit** list appears.

Select Unit...

Medic 1 Engine 1 Medic 2 Engine 2

Engine 3

3. Click the name of the unit you want to work with.

The login screen reappears, with your selection listed for **Unit**.

4. Click in **User Name**, or click **Choose** to the right of **User Name**.

The **Choose User** dialog box appears.

Choose User Submit

Four, Medic	Paramedic	MedicFour
Guest, FH	EMT	Guest
One, Medic	EMT	MedicOne
Three, Medic	Paramedic	MedicThree
Two, Medic	Paramedic	MedicTwo

Filter List by...

Last Name First Name

Q W E R T Y U I O P

A S D F G H J K L

Z X C V B N M Space

Add This Back Clear

5. Specify the name of the user you want to log in as in one of the following ways.

Tip: Several logins are available for evaluating a demonstration copy of FH Medic.

- a. Click **Last Name** or **First Name** to list the users alphabetically by their last or first name.
- b. (Optional) In the blank field above the keyboard, type part or all of the user's last or first name, depending on your selection in the previous step.

The list of user names automatically filters as you type, to display only the user names matching the characters you have entered.

Tip: You can click **Back** to delete the last character in the string in this field, or you can click **Clear** to erase all the characters at once.

Note: The **Add This** button is reserved for other functionality in the application, and does not affect the characters you have typed or the list of user names.

- c. From the list of user names, select the one you want to log into FH Medic with.
- d. In the upper right corner of the dialog box, click **Submit**.

The login screen reappears, with your selection listed for **User Name**.

6. Click in **Password**.

A keyboard appears on the screen.



7. Use the keypad to enter the password, and then click **Submit**.

For the demonstration copy of FH Medic, passwords for the sample logins are listed below.

User name	Password
Guest, FH	demo
One, Medic	MedicOne
Two, Medic	MedicTwo
Three, Medic	MedicThree
Four, Medic	MedicFour

The **Incidents** screen appears in FH Medic, with the **Update Crew** dialog box displayed.

8. Continue with [Specify crew members for the unit](#), on page 4.

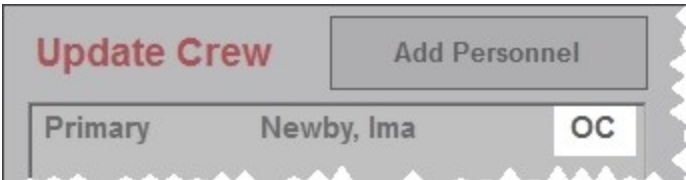

Specify crew members for the unit

After you log in, the **Update Crew** dialog box appears automatically, listing the crew member whose user name and password you logged in with as the primary medic. The primary medic is responsible for documenting the incident the unit and its crew responded to.

You can add or delete crew members from the list, specify who the office in charge (OC) is, and change the primary medic. You can also define non-system individuals on a crew, who participate in a medical dispatch, but who are not regularly scheduled crew members.

1. From **Shift**, select the shift for the incident the data entry is occurring on.
2. (If necessary) Edit the existing crew member list.

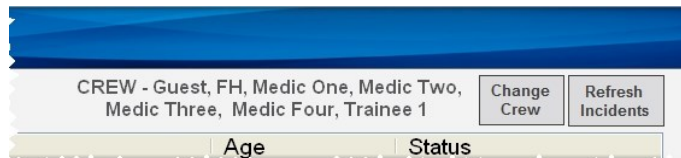
To do this	Do this
Add personnel to the crew	<p>a. At the top of the dialog box, click Add Personnel. The Choose User dialog box appears.</p> <p>b. Using the dialog box as you did when logging in, select an individual's name, and then click Submit. The name of the personnel member appears in the crew member list.</p>

To do this	Do this												
Define the officer in charge (OC)	<p>a. From the list of crew members, select the name of the individual you want to be the officer in charge.</p> <p>b. Click Select as OC.</p> <p>To the right of the crew member's name, the abbreviation OC appears to indicate that the selected crew member is the officer in charge.</p> 												
Change the primary medic	<p>a. From the list of crew members, select the name of the individual you want to be the primary medic.</p> <p>b. Click Make Primary.</p> <p>A keyboard appears on the screen.</p>  <p>d. Use the keypad to enter the password, and then click Submit.</p> <table border="1"> <thead> <tr> <th>User name</th><th>Password</th></tr> </thead> <tbody> <tr> <td>Guest, FH</td><td>demo</td></tr> <tr> <td>One, Medic</td><td>MedicOne</td></tr> <tr> <td>Two, Medic</td><td>MedicTwo</td></tr> <tr> <td>Three, Medic</td><td>MedicThree</td></tr> <tr> <td>Four, Medic</td><td>MedicFour</td></tr> </tbody> </table> <p>The list updates to indicate that the crew member you selected is now the primary medic.</p>	User name	Password	Guest, FH	demo	One, Medic	MedicOne	Two, Medic	MedicTwo	Three, Medic	MedicThree	Four, Medic	MedicFour
User name	Password												
Guest, FH	demo												
One, Medic	MedicOne												
Two, Medic	MedicTwo												
Three, Medic	MedicThree												
Four, Medic	MedicFour												
Add non-system users to the crew	<p>a. In Name, type the name of the non-system user.</p> <p>b. (Optional) In ID, type an identification code appropriate for the non-system user.</p> <p>This identification code can be anything defined by the fire department, the state, or another agency.</p> <p>c. From Type, select an option corresponding to the type of non-system personnel the individual is.</p>												

To do this	Do this
	<p>Example: Non-system individuals include trainees, interns, doctors, police officers, explorers, or additional fire personnel not normally assigned to the unit.</p> <p>Note: The options for this menu are defined by the FH Medic administrator, on the FH Medic Cloud. Information on defining these options is available in the <i>FH® Medic Administrator's Guide</i>, available at http://www.fire-housesoftware.com/webhelp/FHMedic/Default.htm.</p> <p>d. Click Add Non-System User.</p> <p>The name of the non-system user appears in the crew member list in the dialog box.</p>
Remove personnel from the crew	<p>a. From the list of crew members, select the name of the individual you want to delete from the crew.</p> <p>b. Click Remove Selected.</p> <p>The name of the crew member disappears from the list.</p>

3. In the upper right corner of the **Update Crew** dialog box, click **Submit**.

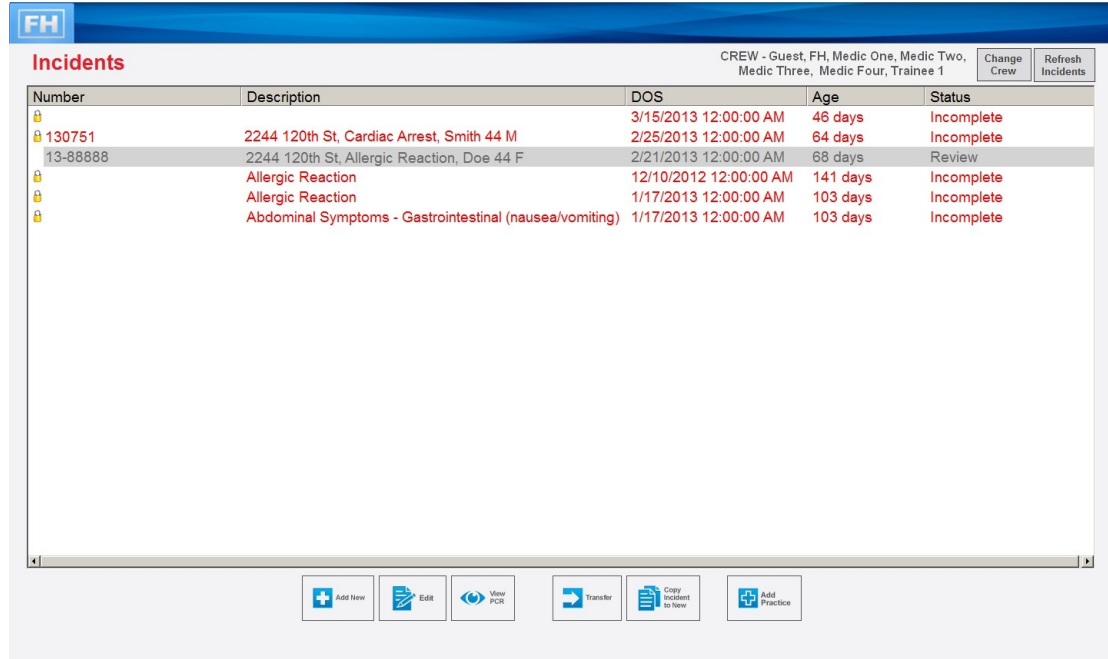
The **Incidents** screen of FH Medic appears, and a summary of the crew members appears in the upper right corner of the user interface.



Note: To access the **Update Crew** dialog box again from the **Incidents** screen, in the upper right corner, click **Change Crew**. From any other screen in FH Medic, choose **FH → Crew**.

Add or edit an incident

After you specify which crew members are associated with a unit, the **Incident** screen of FH Medic appears. If incidents have already been added, a summarized list of them appear in the **Incidents** screen.



Number	Description	DOS	Age	Status
130751	2244 120th St, Cardiac Arrest, Smith 44 M	3/15/2013 12:00:00 AM	46 days	Incomplete
13-88888	2244 120th St, Allergic Reaction, Doe 44 F	2/25/2013 12:00:00 AM	64 days	Incomplete
		2/21/2013 12:00:00 AM	68 days	Review
	Allergic Reaction	12/10/2012 12:00:00 AM	141 days	Incomplete
	Allergic Reaction	1/17/2013 12:00:00 AM	103 days	Incomplete
	Abdominal Symptoms - Gastrointestinal (nausea/vomiting)	1/17/2013 12:00:00 AM	103 days	Incomplete

If information has been entered for an incident, the **Incidents** screen lists the incident's number, description (the provider impression and the patient's last name, age, and gender), incident date of service (DOS), incident age, and incident status.

An incident can have one of the following statuses:

Status	Indicates
Incomplete	You created a new incident and begun entering data for it, but have not finished entering data, validating the data, and marking the incident as complete. The incident remains in the list until it is completed, and can not be released to another group for quality assurance and quality improvement (QA/QI) review or billing.
Complete	You have entered all the required incident data, validated the data, and marked the incident as complete. The incident remains in the list for a specified amount of time, can be accessed by an administrator for QA/QI review, and can be exported for billing. You may view, but not edit, a completed incident.
Review	The incident has been through a QA/QI review and then sent back to you for modification. After you make the changes, you can complete the incident again.
Transfer	The incident was created by another unit, and then transferred to you (the current unit). A transferred incident lists crew members from both units, and can be completed as a normal, incomplete incident.

1. Depending on whether you want to add a new incident or edit the data in an existing incident, do one of the following.

To do this	Do this
Add a new incident	<ul style="list-style-type: none"> At the bottom of the screen, click Add New. A new, blank incident is created,
Add a practice incident	<ul style="list-style-type: none"> At the bottom of the screen, click Add Practice. A new "practice" incident is created, which follows all of the same rules as a regular incident, except that it is not exported and does not appear in reports or incident counts. This feature lets you practice using FH Medic without impacting your real data.
Copy an existing incident and mark it as a new incident	<ul style="list-style-type: none"> At the bottom of the screen, click Copy Incident to New. FH Medic copies an existing incident's information and call times, up to the at-scene time. This feature is useful if you have an incident with multiple patients requiring treatment—you can start a new incident without having to re-enter the incident information for every patient, and only edit the differences for the next patient.
Edit the data in an existing incident	<ol style="list-style-type: none"> 1. Select the incident you want to edit the data for. 2. At the bottom of the screen, click Edit.

Tip: Click **Refresh Incidents** to download transferred calls and update status changes from the FH Medic Cloud.

The **Response** screen appears.

2. (Optional) Continue with [Understand the interface and data entry in it](#), on page 11.
3. Enter or edit the data you need for the incident.
 - [Specify response information](#), on page 16
 - [Record patient information](#), on page 25
 - [Assess the patient's situation](#), on page 50
 - [Document treatments and vitals data](#), on page 69
 - [Describe the outcome of the incident](#), on page 108

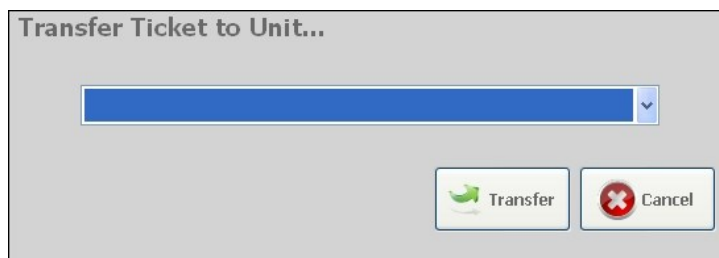
Transfer an incident to another unit

If multiple units responded to an incident, you can transfer an incident to another unit, so that other crews can contribute information to the incident. All participating crew members are documented on the patient care report.

1. (If you are not at the **Incidents** screen) In the upper left corner of the interface, click the **FH** logo, and then choose **Incidents**.

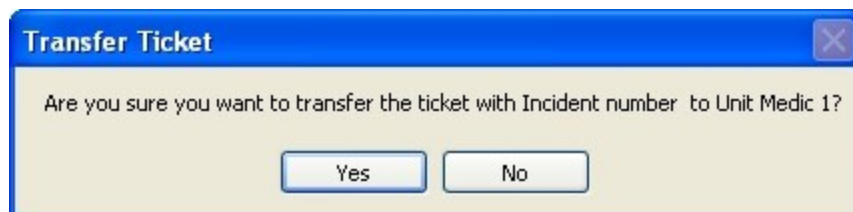


2. From the list, select the incident you want to transfer to another unit.
3. At the bottom of the interface, click **Transfer**.
The **Transfer Ticket to Unit** dialog box appears.



4. From the menu, select the unit you want the incident to be transferred to, and then click **Transfer**.

A confirmation dialog box appears.



The incident disappears from your incident list. The **Get Transfer Tickets** button appears in the upper right of the **Incidents** screen for the receiving unit. When the receiving unit clicks this button, the incident appears in their incident list.

Understand the interface and data entry in it

Once you have logged into FH Medic and added a new incident, the interface is organized into several discrete components:

- A menu under the FH logo
- Tabs organizing data into large groups
- Sub-tabs to further organize fields
- A list of fields on each of the sub-tabs
- A data selection/entry area for entering your data
- Buttons for performing actions with your data

The screenshot shows the FH Medic interface. At the top is a menu bar with the FH logo and tabs for 'Response', 'Patient', 'Situation', 'Events', and 'Summary'. Below this is a sub-tab bar with 'Incident Information', 'Call Times', 'NFIRS', and 'Incident Narrative'. The main area is divided into two sections: 'Location' and 'Incident'. The 'Location' section contains fields for Address, Zip, City, State, Location Type, Map Page, and Comments. The 'Incident' section contains fields for Incident Number, Date of Service, Transport Type, Dispatch Complaint, and Scene Information. To the right of these fields is a large 'data selection/entry area'. At the top right of the main area are 'actions' buttons: 'Quick Actions', 'Validate', 'View PCR', and 'PT Summary'.

Tab	Lets you record
Response	Information about the incident itself, call times, National Fire Incident Reporting System (NFIRS) data, and a narrative.
Patient	The demographics of the person, their past medical history, medications they are taking, allergies they may have, and insurance information.
Situation	Information about the medical or traumatic complaint, the assessments, symptoms, and injuries.
Events	The treatments and supplies used, and record the patient's vital signs.
Summary	Disposition information record signatures, and add additional narrative information.

Tabs and fields with red text indicate required information when entering data for an incident. As you enter data for the required fields, the field names turn black. When all of the required fields on a required sub-tab have data, the name of the sub-tab also turns black. When all of the required fields on all of the required sub-tabs have data, the name and icon of the primary tab turns blue.

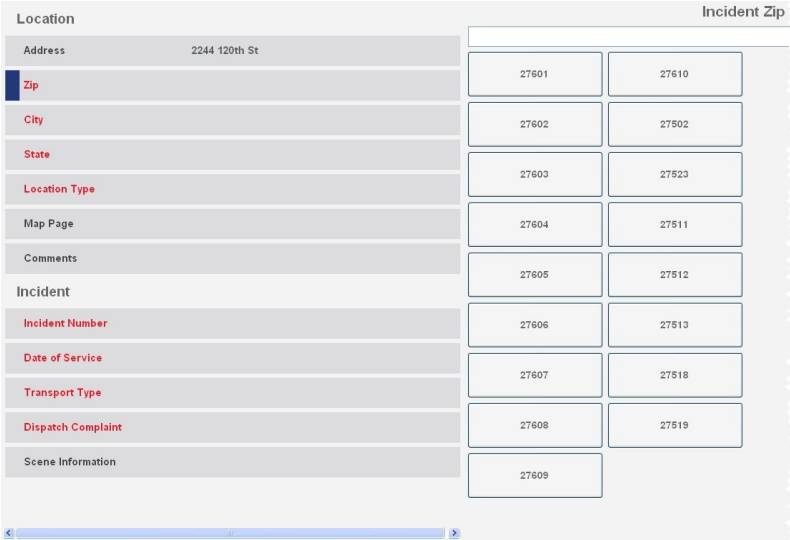
Note: As soon as you enter data, it is relayed to the server using a wireless connection, eliminating the need to "save" data as you work.

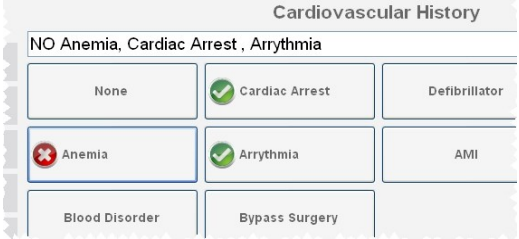
FH Medic is set up to help you enter data as quickly and efficiently as possible by grouping the data on tabs, sub-tabs, and fields. Tabs and fields with red text indicate required information when entering data for an incident.

By default, the incident data screen that appears is the **Response** tab, with the **Incident Information** sub-tab selected, and fields for entering location and incident data will appear on the left side of the interface.

When you click a field on the left side of the interface, depending on the type of data needed for the field and whether pre-defined values already exist in FH Medic, one of the following things appear for data entry.

If this is the case	This happens
No pre-defined values exist in FH Medic	<p>A keyboard appears on the screen, and you can use it to enter the value needed, and then click Submit.</p>

If this is the case	This happens
	<p>Example: If you click Address, a keyboard appears, and you can type in the street address where the incident occurred.</p> <p>If you do not want to enter a value for the field, you can leave the field blank and click Submit.</p> <p>After you click Submit, if the system requires only a single value for the field, FH Medic automatically moves on to the next field and displays either a list of pre-defined choices for the field in the data selection/entry area, or a keyboard for the field.</p>
Pre-defined values exist in FH Medic	<p>A list of pre-defined choices for the field in the data selection/entry area.</p> <p>Example: If you click Zip, a list of the available zip codes appears in the data selection/entry area.</p>  <p>If only one of the pre-defined values is permitted for the field, after you click a value from the list of pre-defined values, FH Medic automatically moves on to the next field, and displays either a list of pre-defined choices for the field in the data selection/entry area, or a keyboard for the field.</p> <div data-bbox="548 1482 1425 1703"> <p>Note: If a blank field appears at the top of the list of pre-defined values, you have the additional option to click it and use the keyboard that appears to enter a value not included in the list of pre-defined values. When you enter a custom value, FH Medic does not move automatically to the next field. To enter the value for the next field, you need to click the field on the right side of the interface.</p> </div> <p>If more than one pre-defined value is permitted for the field, you can make multiple selections in the data selection/entry area. The first time you select a button in the right side of the interface, a green circle with a checkmark appears, and the item is listed in the field at the top of the right side of the interface.</p>

If this is the case	This happens
	<p>If you click a selected button a second time, a red circle with an X appears, and the listing at the top changes to indicate the selection does not apply for the field (example: NO Anemia).</p> <p>If you click the button a third time, the selection status clears entirely.</p> 

Pre-defined values in FH Medic are set up by the FH Medic administrator. Information on defining these values is available in the *FH® Medic Administrator's Guide*, at <http://www.fire-housesoftware.com/webhelp/FHMedic/Default.htm>.

After you provide data for all of the fields on a sub-tab, FH Medic automatically moves on to the next sub-tab of fields. After you provide data for all of the sub-tabs on a tab, FH Medic automatically moves on to the next tab of data needed. In this manner, you enter the data for an incident with a minimum of clicks and keystrokes.

Return to the list of incidents

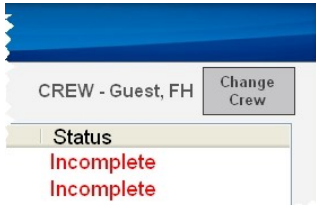
While you are entering or editing data for an incident, or looking at any other screen in the interface, you may want to return to the **Incidents screen** to access a different incident.

- Choose **FH → Incidents**.

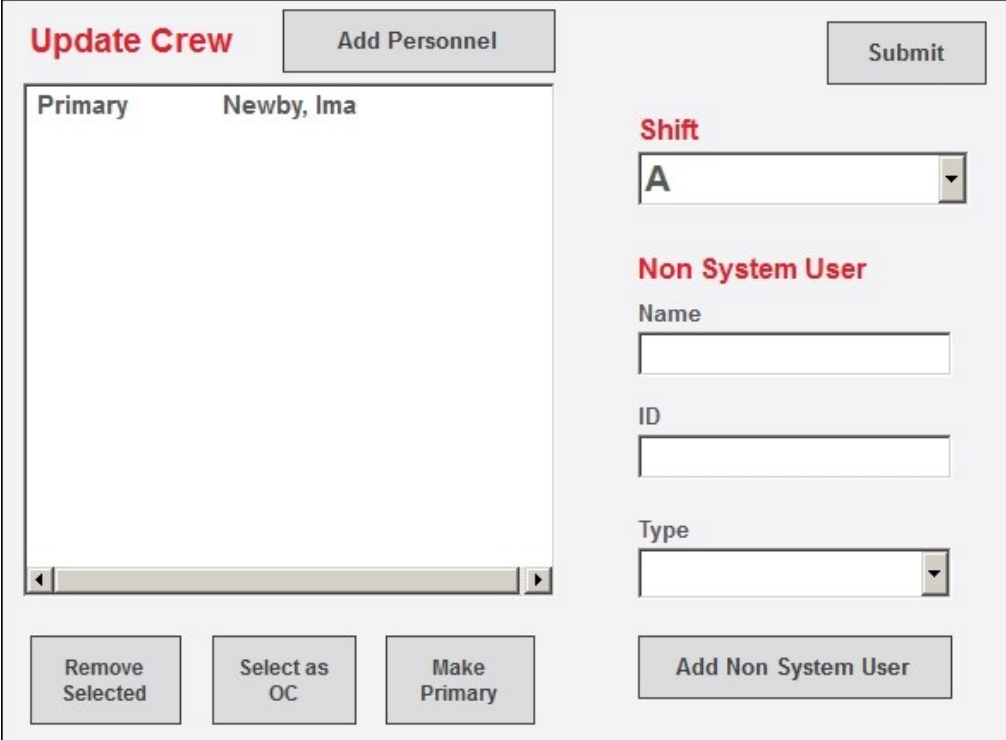
The **Incidents** screen appears, listing all the available incidents.

Change the crew member list

1. Depending on where you are in the FH Medic interface, do one of the following.

If you are here	Do this
At Incidents screen	<ul style="list-style-type: none"> In the upper right corner of the interface, click Change Crew. 
On any data entry tab	<ul style="list-style-type: none"> Choose FH → Crew.

The **Update Crew** dialog box appears.



2. Follow the directions in [Specify crew members for the unit](#), on page 4, to use the options and fields in the dialog box to change the list of crew members.

Specify response information

Response information for an incident includes its location, basic incident information, call times, National Fire Incident Reporting System (NFIRS) information, and a narrative.

Add location and incident data

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

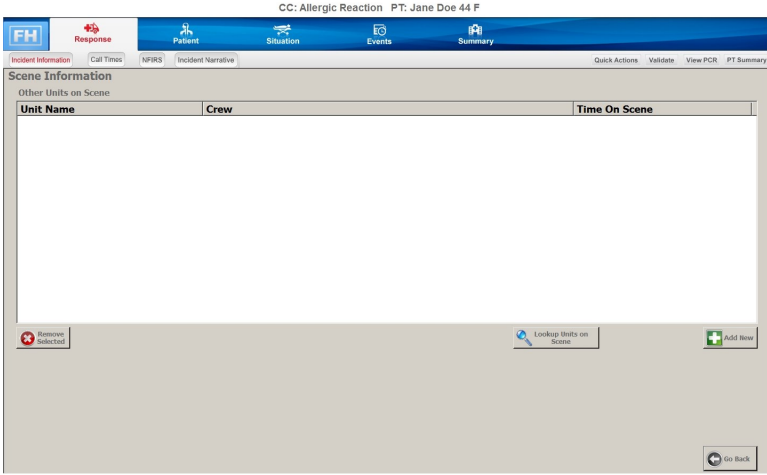
By default, the **Response** tab and **Incident Information** sub-tab are selected, and fields for entering location and incident data appear on the left side of the interface. Fields with red text indicate required information.

The screenshot shows the FH Medic interface. The top navigation bar includes tabs for Response, Patient, Situation, Events, and Summary. The 'Response' tab is selected. Below the navigation bar, there are sub-tabs for Incident Information, Call Times, NFIRS, Incident Narrative, Quick Actions, Validate, View PCR, and PT Summary. The 'Incident Information' sub-tab is selected. The main content area is divided into two sections: 'Location' and 'Incident'. The 'Location' section contains fields for Address, Zip, City, State, Location Type, Map Page, and Comments. The 'Incident' section contains fields for Incident Number, Date of Service, Transport Type, Dispatch Complaint, and Scene Information. Fields with red text indicate required information.

2. Under **Location**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Address	The street address where the incident occurred.
Zip	The name of the state where the incident occurred, and the numerical code assigned by the U.S. Postal Service to all U.S. jurisdictions.
City	The name of the city where the incident occurred. <div>Note: If the incident occurred in an unincorporated area, use the city found in the mailing address for the incident location.</div>
State	The name of the state where the incident occurred.
Location Type	A description of the location where the incident occurred.
Map Page	The page number the location can be found on in the fire department's map book.
Comments	Additional comments about the location of the incident.

3. Under **Incident**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed				
Incident Number	<p>A unique incident number assigned by the fire department or dispatch center for every incident to which the department is called.</p> <div> <p>Note: You may need to obtain this number from an alarm or dispatch center.</p> </div>				
Date of Service	The date the dispatcher was notified about the incident.				
Transport Type	The type of transportation used to take a patient to a facility for treatment. This is typically an Advanced Life Support (ALS) or Basic Life Support (BLS) apparatus.				
Dispatch Complaint	The reason emergency personnel were initially dispatched to the scene.				
Scene Information	<p>A list of other units and crew members at the incident scene.</p> <ol style="list-style-type: none"> Click Show. The Scene Information screen appears.  <ol style="list-style-type: none"> Do any of the following. <table border="1"> <thead> <tr> <th>To do this</th><th>Do this</th></tr> </thead> <tbody> <tr> <td>Add a unit to the scene</td><td> <ol style="list-style-type: none"> On the right side of the screen, click Add New. The Unit on Scene Information dialog box appears. </td></tr> </tbody> </table>	To do this	Do this	Add a unit to the scene	<ol style="list-style-type: none"> On the right side of the screen, click Add New. The Unit on Scene Information dialog box appears.
To do this	Do this				
Add a unit to the scene	<ol style="list-style-type: none"> On the right side of the screen, click Add New. The Unit on Scene Information dialog box appears. 				

Field	Information needed						
	<table><tr><th>To do this</th><th>Do this</th></tr><tr><td></td><td><div><div>Unit on Scene Information</div><div><div>Unit Name</div><div></div><div>Select Unit</div></div><div><div>Crew</div><div></div><div>Remove</div></div><div><div>List Unit Users</div><div>List All Users</div><div></div><div>Add</div></div><div><div>Time On Scene</div><div></div></div><div>Submit</div></div><div><div><div>b. Click Select Unit.</div><div>The Select Unit dialog box appears, listing the units you can add to the scene.</div><div>c. Click the unit you want to add to the scene.</div><div>d. Under Crew, click either List Unit Users or List All Users.</div><div>Depending on your selection, all the crew members in FH Medic, or only the crew members assigned to the unit you selected, will be listed in the next step.</div><div>e. From the menu below List Unit Users or List All Users, select the name of the crew member you want to add to the incident.</div><div>f. Click Add.</div><div>The name of the selected crew member appears in the Crew list above List Unit Users or List All Users.</div><div>g. Repeat step f as many times as needed to list the additional crew members at the scene.</div><div>h. (If you added a crew member who was not at the scene) From the Crew list, select the name of the crew member you want to delete, and then click Remove.</div><div>i. Click Time On Scene, and then enter the time the crew member arrived on the scene.</div><div>j. Click Submit.</div><div>The name of the unit, crew member, and time the crew member arrived on the scene appear on the Scene Information screen.</div></div></div></td></tr><tr><td>Remove a unit or</td><td>a. Select the unit or crew member you want to remove from the list.</td></tr></table>	To do this	Do this		<div><div>Unit on Scene Information</div><div><div>Unit Name</div><div></div><div>Select Unit</div></div><div><div>Crew</div><div></div><div>Remove</div></div><div><div>List Unit Users</div><div>List All Users</div><div></div><div>Add</div></div><div><div>Time On Scene</div><div></div></div><div>Submit</div></div> <div><div><div>b. Click Select Unit.</div><div>The Select Unit dialog box appears, listing the units you can add to the scene.</div><div>c. Click the unit you want to add to the scene.</div><div>d. Under Crew, click either List Unit Users or List All Users.</div><div>Depending on your selection, all the crew members in FH Medic, or only the crew members assigned to the unit you selected, will be listed in the next step.</div><div>e. From the menu below List Unit Users or List All Users, select the name of the crew member you want to add to the incident.</div><div>f. Click Add.</div><div>The name of the selected crew member appears in the Crew list above List Unit Users or List All Users.</div><div>g. Repeat step f as many times as needed to list the additional crew members at the scene.</div><div>h. (If you added a crew member who was not at the scene) From the Crew list, select the name of the crew member you want to delete, and then click Remove.</div><div>i. Click Time On Scene, and then enter the time the crew member arrived on the scene.</div><div>j. Click Submit.</div><div>The name of the unit, crew member, and time the crew member arrived on the scene appear on the Scene Information screen.</div></div></div>	Remove a unit or	a. Select the unit or crew member you want to remove from the list.
To do this	Do this						
	<div><div>Unit on Scene Information</div><div><div>Unit Name</div><div></div><div>Select Unit</div></div><div><div>Crew</div><div></div><div>Remove</div></div><div><div>List Unit Users</div><div>List All Users</div><div></div><div>Add</div></div><div><div>Time On Scene</div><div></div></div><div>Submit</div></div> <div><div><div>b. Click Select Unit.</div><div>The Select Unit dialog box appears, listing the units you can add to the scene.</div><div>c. Click the unit you want to add to the scene.</div><div>d. Under Crew, click either List Unit Users or List All Users.</div><div>Depending on your selection, all the crew members in FH Medic, or only the crew members assigned to the unit you selected, will be listed in the next step.</div><div>e. From the menu below List Unit Users or List All Users, select the name of the crew member you want to add to the incident.</div><div>f. Click Add.</div><div>The name of the selected crew member appears in the Crew list above List Unit Users or List All Users.</div><div>g. Repeat step f as many times as needed to list the additional crew members at the scene.</div><div>h. (If you added a crew member who was not at the scene) From the Crew list, select the name of the crew member you want to delete, and then click Remove.</div><div>i. Click Time On Scene, and then enter the time the crew member arrived on the scene.</div><div>j. Click Submit.</div><div>The name of the unit, crew member, and time the crew member arrived on the scene appear on the Scene Information screen.</div></div></div>						
Remove a unit or	a. Select the unit or crew member you want to remove from the list.						

Field	Information needed					
	<table><tr><th>To do this</th><th>Do this</th></tr><tr><td>crew member from the scene</td><td>b. Click Remove Selected.</td></tr></table>		To do this	Do this	crew member from the scene	b. Click Remove Selected .
To do this	Do this					
crew member from the scene	b. Click Remove Selected .					
	3. In the lower right corner of the screen, click Go Back .					
Prior Aid	Notes about what aid was given to the patient before the medics arrived.					

Record call response times

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

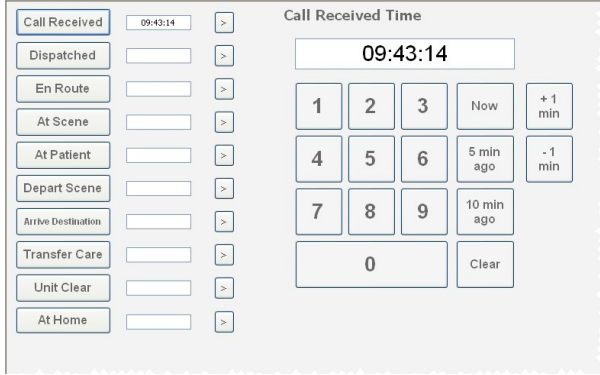

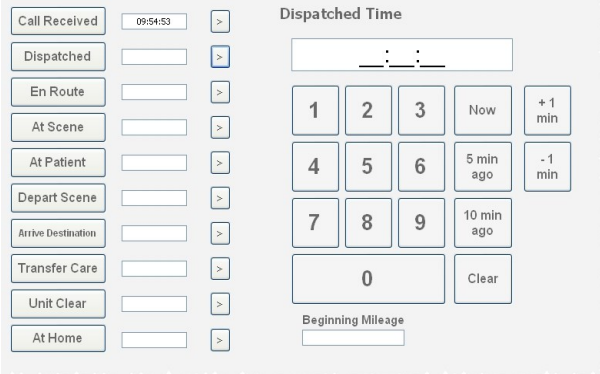
By default, the **Response** tab and **Incident Information** sub-tab are selected.

2. Click the **Call Times** sub-tab.

Fields for specifying a variety of times appear on the left side of the interface.

Call Received	<input type="text"/>	>
Dispatched	<input type="text"/>	>
En Route	<input type="text"/>	>
At Scene	<input type="text"/>	>
At Patient	<input type="text"/>	>
Depart Scene	<input type="text"/>	>
Arrive Destination	<input type="text"/>	>
Transfer Care	<input type="text"/>	>
Unit Clear	<input type="text"/>	>
At Home	<input type="text"/>	>

- For each of the fields, do one of the following.

To do this	Do this
Enter the current system time on your computer	<ol style="list-style-type: none"> Click the button for the field. The current time appears in the field to the right of the button, and a number pad with additional buttons and a time display appears in the data selection/entry area.  (If necessary) Adjust the time displayed with the Now, 5 min ago, 10 min ago, +1 min, or -1 min buttons. (Optional) Click Clear, and then click the number buttons to re-enter a time.
Manually enter a time	<ol style="list-style-type: none"> Click the button with the greater-than symbol  to the right of the time field you want to fill. A number pad with additional buttons and a blank time display appears in the data selection/entry area.  Do any of the following. <ul style="list-style-type: none"> Click Now to enter the current system time on your computer. Click 5 min ago or 10 min ago to enter the current system time on your computer, minus five or ten minutes, respectively.

To do this	Do this
	<ul style="list-style-type: none"> Click the number buttons to enter a time. <p>3. (Optional) Adjust the time displayed with the +1 min or -1 min buttons.</p>

Note: Some of the fields have an additional mileage field below the number pad, so that you can record the odometer reading on the apparatus at various points of travel during the incident.

Field	Information needed
Call Received	The time the phone rings (911 call to public safety answering point or other designated entity) requesting emergency medical service (EMS) support.
Dispatched	The time dispatch was notified by the 911 call taker (if a separate entity).
En Route	The time the unit responded (the time the vehicle started moving).
At Scene	The time the responding unit arrived on the scene (the time the vehicle stopped moving).
At Patient	The time the responding unit arrived at the patient's side.
Arrive Destination	The time the responding unit arrived with the patient at the destination or transfer point.
Transfer Care	The time the patient was transferred from this EMS agency to another EMS agency for care.
Unit Clear	The time the responding unit left the scene (started moving).
At Home	The time the responding unit was back in their service area. In agencies who utilize Agency Status Management, home location is the service area as assigned through the agency status management protocol.

4. In the lower left corner of the screen, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Responding Mileage	The odometer reading on the unit before leaving to respond to the incident.
At Scene Mileage	The odometer reading on the responding unit when it arrived on the scene.
At Destination Mileage	The odometer reading on the responding unit when it arrived with the patient at the destination or transfer point.
Clear Mileage	The odometer reading on the responding unit when it left the scene.

Add NFIRS data

You can also record data for National Fire Incident Reporting System (NFIRS) in FH Medic.

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

2. Click the **NFIRS** sub-tab.

Fields for specifying NFIRS data appear on the left side of the interface.



The screenshot shows a user interface for entering NFIRS data. It features a header labeled 'NFIRS' and five input fields stacked vertically: 'Incident Type', 'Alarm Type', 'Aid Given / Received', 'Property Use', and 'Action Taken'. Each field is represented by a light gray rectangular box with its label inside.

3. Under **NFIRS**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Incident Type	A description of the actual situation emergency personnel found on the scene when personnel arrived.
Alarm Type	The definition of an alarm, determined at the local level.
Aid Given / Received	An indication of whether assistance was given or received from another fire department to help resolve an incident. That assistance can be in the form of personnel or equipment from one or more departments.
Property Use	A description of the type of location where the incident occurred.
Action Taken	The duties performed at the incident scene by the responding personnel.

Enter an incident narrative

The incident report is an official record of an incident, and must accurately describe the incident and the actions taken to mitigate it. While many facts can be recorded in code fields, some information can be presented only in a detailed narrative. Critical information may be left out unless the narrative report is completed. Information that should be included in the narrative includes observations and actions taken. They should be reported in a logical order—usually chronological.

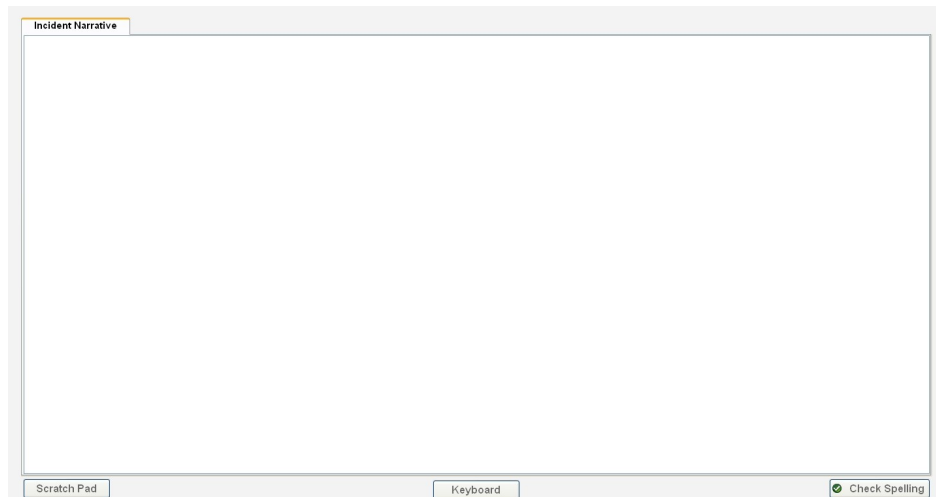
You should use the narrative report to describe scene conditions, including property damage. Also describe the condition of the premises when you left, report any remaining hazards, and summarize the incident.

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

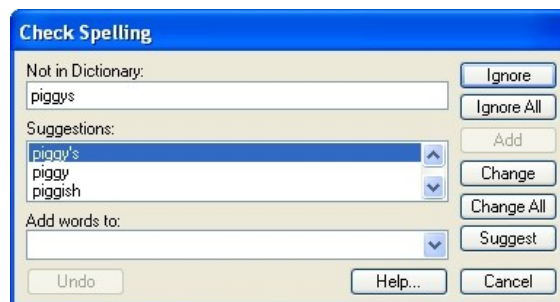
2. Click the **Incident Narrative** sub-tab.

A large text area for entering text about the incident appears.

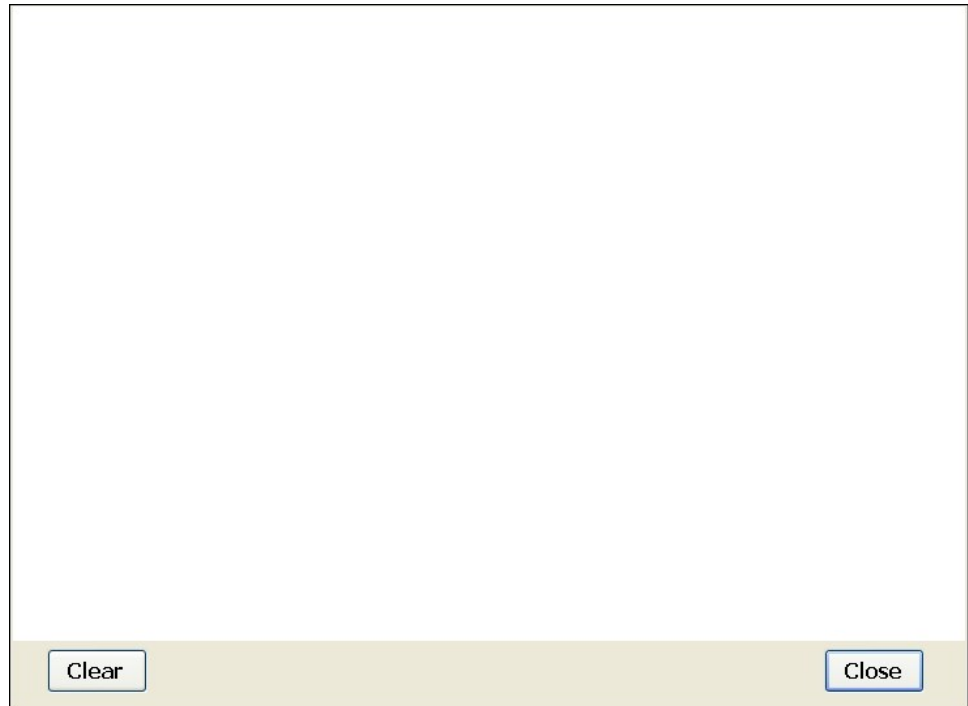


3. Click in the large text area, or click **Keyboard** at the bottom of the tab.
A keyboard appears over the screen.
4. Use the keyboard to type a narrative describing the incident, and then click **Submit**.
5. In the lower right corner of the tab, click **Check Spelling**.

If spelling errors are found in your text, the **Check Spelling** dialog box appears.



6. (If the **Check Spelling** dialog box appears) Use the dialog box to correct any spelling errors in your text.
7. (Optional) Add hand-written notes or sketches to the incident narrative.
 - a. In the lower left corner of the tab, click **Scratch Pad**.
A blank drawing dialog box appears.



- b. Using your finger, stylus, or a mouse pointer, draw or write in the scratch pad window.
A black, two-pixel line follows your movements.
Tip: If you are unsatisfied with your results, click **Clear** to remove all lines from the scratch pad window.
 - c. Click **Close**.
The notes or drawings on the scratch pad remain available until the incident is closed, and you can add to them as needed by repeating steps a–c.

Record patient information

Patient information includes demographic (personal, address, and financial) information, past medical history, medication, allergies, and insurance data.

Specify the patient's personal information


1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
2. Click the **Patient** tab, and then click the **Demographics** sub-tab.
Fields for specifying the patient's personal information appear on the left side of the interface.



3. Under **Personal Info**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Tip: If the patient already exists in FH Medic from a previous incident, you can pull up the patient's existing data, as described in [Search for a patient](#), on page 27. If you have a driver's license scanner available, you can read the patient's information from their driver's license, as described in [Read information from a driver's license](#), on page 29.

Field	Information needed
Last Name, First Name, Middle Initial	The patient's last (family) name, first (given) name, and middle initial (if any).

Field	Information needed
DOB	<p>The patient's date of birth.</p> <div> <p>Note: If you are not able to obtain the patient's date of birth, in the number pad on the right side of the interface, click UTO (unable to obtain).</p> </div> <p>FH Medic automatically calculates the patient's age and displays it in Age.</p>
Age Units	The division of time (years, months, days, hours, minutes) to associate with the value in Age .
Race	The identification of the race of the casualty, based on U.S. Office of Management and Budget (OMB) designations.
Sex	The patient's gender.
Phone	<p>The patient's home or primary telephone number.</p> <p>Tip: If the phone number is not available, click UTO (unable to obtain).</p>
Height (feet-inches)	The patient's height, in feet and inches.
Weight	<p>The patient's weight, in pounds or kilograms.</p> <p>Tip: To indicate the units you are using for the patients weight, click the button to the right of the field in the data selection/entry area. The label on this button changes between lbs and kg, to indicate the current unit for the weight.</p>  <p>Tip: If you cannot establish the patient's weight, click UTO (unable to obtain).</p>
DL Number	The patient's driver's license number.
SSN	<p>The patient's Social Security Number (SSN).</p> <p>Tip: If the SSN is not available, click UTO (unable to obtain).</p>

Search for a patient

If the patient already exists in FH Medic from a previous incident, you can call up his existing information instead of re-entering it again for the current incident.

1. At the bottom of the tab, click **Lookup Patient**.

The **Search Existing Patients** dialog box appears.

2. Do one of the following.

To do this	Do this
Find a patient by their Social Security Number (SSN)	<ol style="list-style-type: none"> 1. Click Search by SSN. The dialog box updates to display the SSN field. 2. Click SSN. The Patient Social Security Number dialog box appears. <div data-bbox="873 1222 1206 1600" data-label="Form"> </div> 3. Use the keypad to type the patient's SSN, then click Submit. The value you specified appears in SSN. 4. Click Search. If an SSN matching your entry is found, the patient's record appears in the list in the dialog box.

To do this	Do this
Find a patient by their name	<ol style="list-style-type: none"> Click Search by Name and DOB. The fields in the dialog box update to display the First Name, Last Name, and DOB fields. Click First Name. A keyboard appears on the screen. Use the keypad to type the patient's first name, and then click Submit. Repeat the previous two steps for Last Name. Click DOB (date of birth). The Patient Date of Birth dialog box appears. <div data-bbox="878 705 1209 1085" data-label="Form"> <p>The image shows a 'Patient Date of Birth' dialog box. It features a date entry field at the top with a placeholder '___/___/___'. Below this is a numeric keypad with buttons for digits 1 through 9, 0, and a 'Now' button. To the right of the keypad are 'Back', 'Clear', and 'Enter' buttons. At the bottom center is a blue 'Submit' button with a circular icon.</p> </div> Use the dialog box to enter the patient's date of birth, and then click Submit. Click Search. If patient name or date of birth matching your specifications is found, the patient's record appears in the list in the dialog box.

3. Depending on whether the patient is found, do one of the following.

Was the patient found?	Do this
No	<ul style="list-style-type: none"> In the lower left corner of the dialog box, click Go back to return to the Demographics sub-tab. The Demographics sub-tab reappears with blank fields.
Yes	<ol style="list-style-type: none"> In the results list, select the patient. In the lower right corner of the dialog box, click Select This Patient. The Demographics sub-tab reappears, and the patient's data populates the fields.

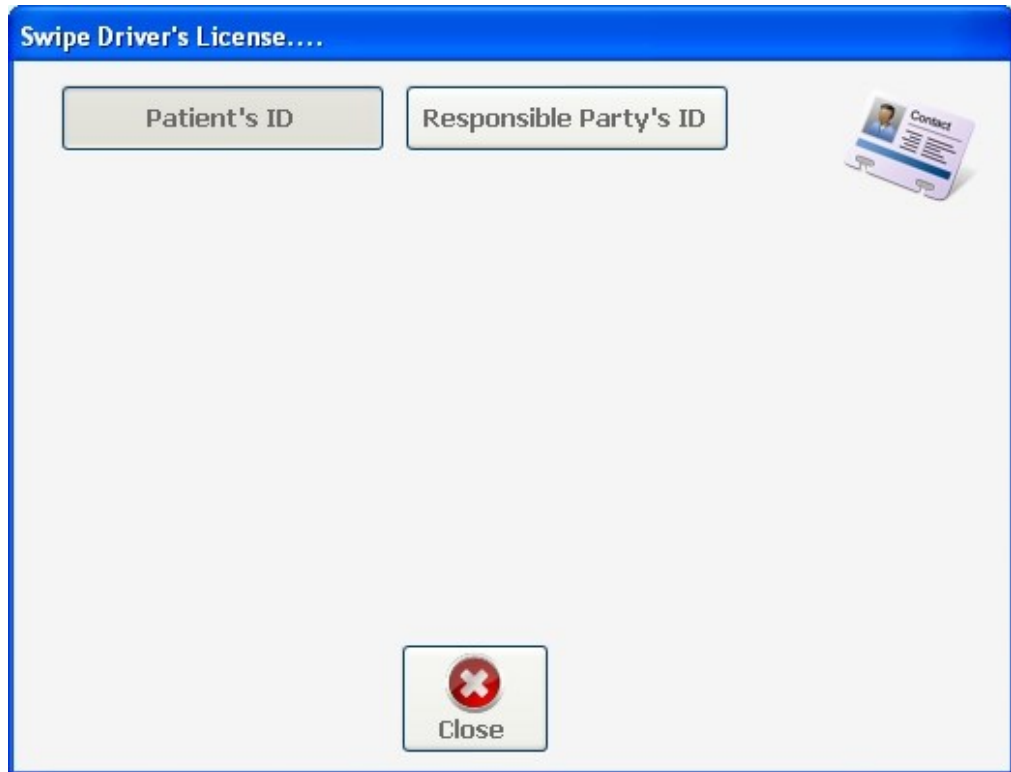
Read information from a driver's license

If the patient or a responsible party for the patient has a driver's license, and if you have a driver's license scanner available, you can swipe the driver's license through the scanner and transfer the information on the license into FH Medic instead of entering it manually.

Note: Not all states issue driver's licenses that can be read by driver's license scanner.

1. At the bottom of the tab, click **Scan Drivers License**.

The **Swipe Driver's License** dialog box appears.



2. Depending on whose driver's license you will scan, click either **Patient's ID** or **Responsible Party's ID**.
3. Swipe the driver's license through the scanner and follow any directions provided with the scanner for its operation.

If the scanner can read the information on the driver's license, data appears in the **Swipe Driver's License** dialog box.

4. Click **Close**.

The **Demographics** sub-tab reappears. If the driver's license was successfully read, the patient's data populates the fields.

Specify the patient's home address

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

2. Click the **Patient** tab, and then click the **Demographics** sub-tab.

Fields for specifying the information about the patient appear on the left side of the interface. Fields with red text indicate required information.

Tip: If the patient already exists in FH Medic from a previous incident, you can pull up the patient's existing data, as described in [Search for a patient](#), on page 27. If you have a driver's license scanner available, you can read the patient's information from their driver's license, as described in [Read information from a driver's license](#), on page 29.

3. Scroll down through the fields until the **Home Address** section appears.

The screenshot shows a scrollable list of fields under the 'Home Address' heading. The fields are: 'Address 1' (with red text), 'Address 2', 'Zip' (with red text), 'City' (with red text), 'State' (with red text), 'County' (with red text), 'Resident or Non-resident', and 'Financial Guarantor'.

4. Under **Home Address**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Address 1, Address 2	The patient's home mailing or street address. Tip: When you click this field, the Copy Address from Incident and UTO buttons appear in the data selection/entry area. You can click the first button to copy the information from the Response tab, Location sub-tab. If you click UTO (unable to obtain), the address fields are no longer required.
ZIP	The patient's home ZIP code of residence. This is the numerical code assigned by the U.S. Postal Service to all U.S. jurisdictions.
City	The patient's home city, township, or residence. Note: If the patient lives in an unincorporated area, use the city found in the mailing address for the patient.

Field	Information needed
State	The home state, territory, or province, or District of Columbia where the patient resides.
County	The patient's home county, parish, or residence.
Resident or Non-resident	An indication of whether or not the patient is a resident in the area (district, county, zone, city, and so forth) where the incident occurred. You can use this information to analyze statistics, calculate applicable billing, and so forth.

Specify the patient's financial guarantor

A financial guarantor is a third party who promises to provide payment on a bond, loan, or other liability in the event of default. While many guarantees apply to debt instruments, they may also be used for day-to-day expenses, such as those incurred during an incident.

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

2. Click the **Patient** tab, and then click the **Demographics** sub-tab.

Fields for specifying the information about the patient appear on the left side of the interface.

Tip: If the patient already exists in FH Medic from a previous incident, you can pull up the patient's existing data, as described in [Search for a patient](#), on page 27. If you have a driver's license scanner available, you can read the patient's information from their driver's license, as described in [Read information from a driver's license](#), on page 29.

3. Scroll down through the fields until the **Financial Guarantor** section appears.

The screenshot shows a web application interface with a sidebar on the left containing various tabs. The 'Patient' tab is selected, and the 'Demographics' sub-tab is active. The main content area displays a form titled 'Financial Guarantor' with several input fields: 'Last Name', 'First Name', 'Relationship', 'Address', and 'Phone'. The form is partially obscured by a vertical scrollbar on the right side.

- Under **Financial Guarantor**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Last Name, First Name	The full name of the financial guarantor of the patient.
Relationship	The relationship of the financial guarantor to the patient.
Address	The home mailing or street address, city, state, and zip code for the financial guarantor of the patient.
Phone	The phone number of the financial guarantor. If this number is not available, click UTO (unable to obtain) in the data selection/entry area.

Collect the patient's medical history

- (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

- Click the **Patient** tab, and then click the **Past History** sub-tab.

Fields for specifying the patient's medical history information appear on the left side of the interface.

The screenshot displays a web interface titled "Patient Past Medical History". On the left side, there is a vertical list of medical categories, each in a light gray box: Cardiovascular, Cancer, Neurological, Gastrointestinal, Genitourinary, Infectious, Metabolic / Endocrine, Respiratory, Psychological, Womens Health, Surgical, and Immunizations. The right side of the interface is mostly blank, with a horizontal scrollbar at the bottom indicating that the list of categories can be scrolled horizontally.

3. Under **Patient Past Medical History**, for each of the fields, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Cardiovascular	Conditions the patient may have relating to the heart, blood vessels, or the circulation.
Cancer	Types of cancer the patient may have.
Neurological	Any disorders of the body's nervous system the patient may have.
Gastrointestinal	Conditions the patient may have relating to the stomach and intestine, and sometimes to all the structures from the mouth to the anus.
Genitourinary	Conditions the patient may have caused by infections affecting the genital area and urinary system.
Infectious	Any illness the patient may have that can be transmitted to people and organisms through the environment.
Metabolic / Endocrine	Conditions the patient may have which affect the body's production of certain hormones, or the body's ability to process certain nutrients and vitamins.
Respiratory	Conditions the patient may have relating to the organs in the body that let the patient breathe.
Psychological	Conditions the patient may have related to the mental and emotional state of a person.
Women's Health	Conditions the patient may have related to issues specific to human female anatomy. These often relate to structures such as female genitalia and breasts or to conditions caused by hormones specific to females.
Surgical	Types of surgery performed on the patient in the past.
Immunizations	An indication of whether or not (if known) the patient has been immunized, and if those immunizations are up-to-date.

List the patient's medications

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

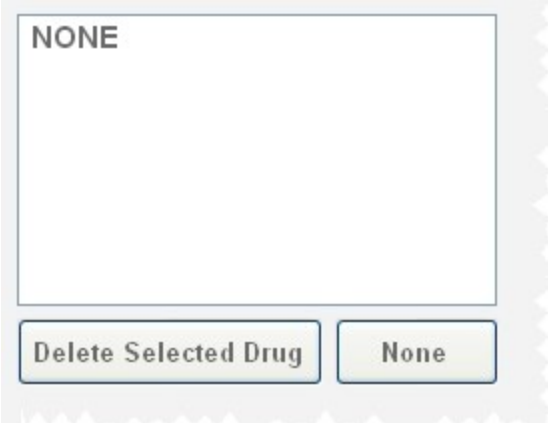
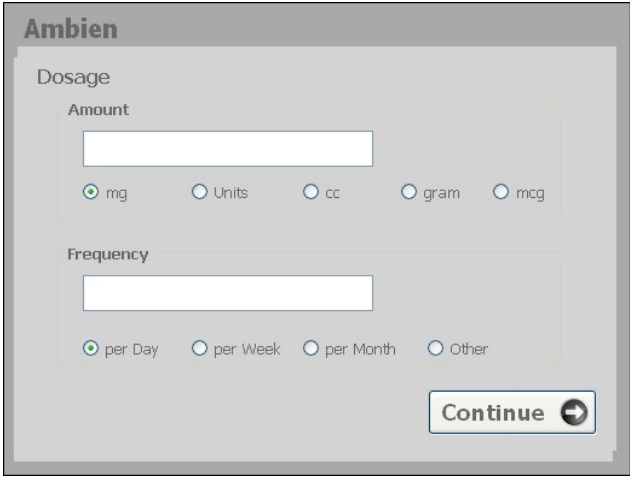
By default, the **Response** tab and **Incident Information** sub-tab are selected.

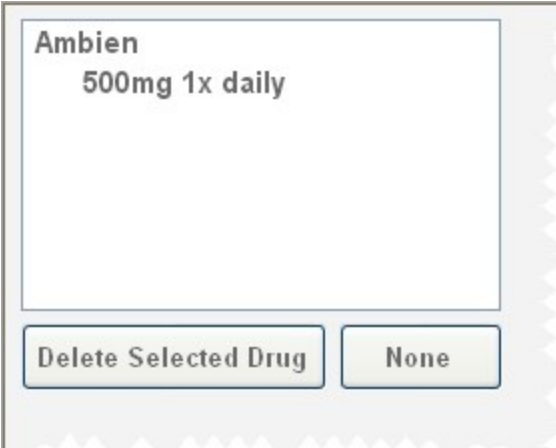
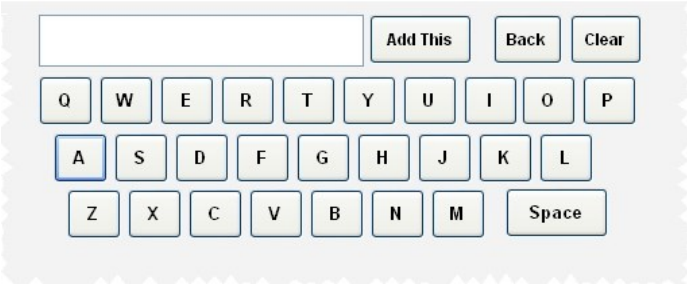
2. Click the **Patient** tab, and then click the **Meds** sub-tab.


Fields for specifying any medication the patient is taking appear on the left side of the interface, and a list of medications for you to quickly choose from is listed in alphabetical order at the bottom of the interface.

Tip: You can scroll backward and forward through the list of medications by clicking the right and left arrow buttons below the list.

3. Do any of the following.

To do this	Do this
<p>Indicate the patient is not taking medication.</p>	<ul style="list-style-type: none"> Below the list in the upper left corner of the interface, click None. <p>The word NONE appears in the medication list.</p> 
<p>Add medications the patient is taking to the list.</p>	<p>a. Scroll through the list of medications as needed and click a medication the patient is taking.</p> <p>A dialog box for specifying the amount of the dose and frequency appears.</p>  <p>b. Specify the amount and frequency the patient takes the medication.</p> <ol style="list-style-type: none"> For Amount, click the field, and then use the keyboard that appears to type the amount of the medication the patient takes each time. From the list below Amount, select the units for the amount taken. In Frequency, click the field, and then use the keyboard

To do this	Do this
	<p>that appears to type the number of times the patient takes the medication.</p> <p>iv. From the list below Frequency, select the time interval the patient takes the medication in.</p> <p>v. Click Continue.</p> <p>The medication is added to the list in the upper left corner of the interface.</p>  <p>c. Repeat steps a–b as needed to list all the medications the patient is taking.</p>
<p>Add a medication which is not listed.</p>	<p>a. Click in the field for the keyboard to the right of the medication list, and type the name of the medication the patient is taking.</p>  <p>b. Click Add This.</p> <p>A dialog box for specifying the amount of the dose and frequency appears.</p>

To do this	Do this
	<div data-bbox="764 268 1390 741"> <p>Ambien</p> <p>Dosage</p> <p>Amount</p> <input data-bbox="844 394 1133 436" type="text"/> <p> <input checked="" data-bbox="844 451 860 472" type="radio"/> mg <input data-bbox="950 451 966 472" type="radio"/> Units <input data-bbox="1063 451 1079 472" type="radio"/> cc <input data-bbox="1161 451 1177 472" type="radio"/> gram <input data-bbox="1258 451 1274 472" type="radio"/> mcg </p> <p>Frequency</p> <input data-bbox="844 541 1133 583" type="text"/> <p> <input checked="" data-bbox="844 598 860 619" type="radio"/> per Day <input data-bbox="950 598 966 619" type="radio"/> per Week <input data-bbox="1063 598 1079 619" type="radio"/> per Month <input data-bbox="1185 598 1201 619" type="radio"/> Other </p> <p>Continue </p> </div> <p data-bbox="695 766 1421 867">c. Specify the amount and frequency the patient takes the medication, as described above in the instructions for adding medications the patient is taking to the list.</p>
Delete a medication from the list the patient is taking.	<p data-bbox="695 888 1396 951">a. In the list in the upper left corner of the interface, select the medication you want to delete.</p> <p data-bbox="695 972 1185 1045">b. Click Delete Selected Drug. The medication disappears from the list.</p>

List any allergies the patient has

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

2. Click the **Patient** tab, and then click the **Allergies** sub-tab.

Fields for specifying the information about allergies the patient has appear on the left side of the interface.



The screenshot shows a user interface for the 'Allergies' sub-tab. It features a vertical list of four categories: 'Medications', 'Environment', 'Food', and 'Insects'. Each category is represented by a light gray rectangular button with its name in a small, dark font. The buttons are stacked vertically, and the 'Allergies' title is at the top left of the panel.

3. Under **Allergies**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Medications	A list of medications (penicillin, aspirin, morphine and so forth) which trigger an allergic reaction in the patient.
Environment	A list of environmental factors (dust, latex, pollen, and so forth) which trigger an allergic reaction in the patient.
Food	A list of foods (shellfish, gluten, dairy, and so forth) which trigger an allergic reaction in the patient.
Insects	A list of insect bites or stings (from ants, bees, spiders, and so forth) which trigger an allergic reaction in the patient.

Specify insurance information

- 1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
- 2. Click the **Patient** tab, and then click the **Insurance** sub-tab.
Fields appear for specifying the information about any insurance the patient has.

Add Insurance Type

Medicare

Medicaid

Private Insurance

Other Payer or Self Pay

Not Obtained

Type	Information
------	-------------

Edit Selected

Delete Selected

Forms


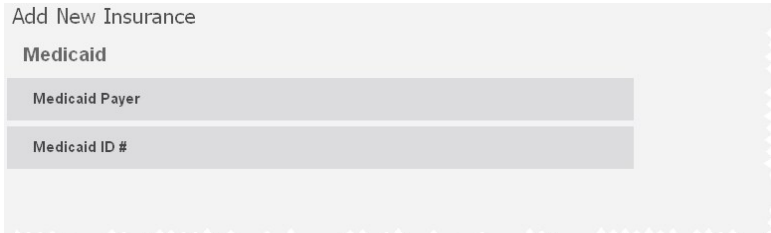
ABN Form


PCS Form


Hospital Face Sheet ☐ Yes ☐ No

- 3. Under **Add Insurance Type**, add insurance information in one of the following ways.

To do this	Do this
Add other payer or self-pay information	<div><div>1. Click Not Obtained.</div><div>A field for indicating why you could not obtain the information appears.</div><div><div>Add New Insurance</div><div>Not Obtained</div><div>Reason</div></div></div> <div><div>2. Click Not Obtained.</div><div>A list of reasons appears in the data selection/entry area for why insurance information could not be obtained.</div></div> <div><div>3. In the data selection/entry area, click the reason that applies to the patient.</div></div>

To do this	Do this						
Add Medicare insurance	<ol style="list-style-type: none"> Click Medicare. Fields appear for specifying Medicare information.  Under Medicare, enter data as described in Understand the interface and data entry in it, on page 11. <table border="1"> <thead> <tr> <th>Field</th><th>Information needed</th></tr> </thead> <tbody> <tr> <td>Medicare Payer</td><td>The health care program that is submitting the medical bills for the patient to Medicare.</td></tr> <tr> <td>Medicare ID #</td><td>The number that uniquely identifies a health care provider and is used on billing forms submitted to Medicare.</td></tr> </tbody> </table> 	Field	Information needed	Medicare Payer	The health care program that is submitting the medical bills for the patient to Medicare.	Medicare ID #	The number that uniquely identifies a health care provider and is used on billing forms submitted to Medicare.
Field	Information needed						
Medicare Payer	The health care program that is submitting the medical bills for the patient to Medicare.						
Medicare ID #	The number that uniquely identifies a health care provider and is used on billing forms submitted to Medicare.						
Add Medicaid insurance	<ol style="list-style-type: none"> Click Medicaid. Fields appear for specifying Medicaid information.  Under Medicaid, enter data as described in Understand the interface and data entry in it, on page 11. <table border="1"> <thead> <tr> <th>Field</th><th>Information needed</th></tr> </thead> <tbody> <tr> <td>Medicaid Payer</td><td>The list of insurance companies working with Medicaid to submit the medical bills for the patient to Medicaid.</td></tr> <tr> <td>Medicaid ID #</td><td>The number that uniquely identifies a health care provider and is used on billing forms submitted to Medicaid.</td></tr> </tbody> </table> 	Field	Information needed	Medicaid Payer	The list of insurance companies working with Medicaid to submit the medical bills for the patient to Medicaid.	Medicaid ID #	The number that uniquely identifies a health care provider and is used on billing forms submitted to Medicaid.
Field	Information needed						
Medicaid Payer	The list of insurance companies working with Medicaid to submit the medical bills for the patient to Medicaid.						
Medicaid ID #	The number that uniquely identifies a health care provider and is used on billing forms submitted to Medicaid.						

To do this	Do this																
Add private insurance	<p>1. Click Private Insurance.</p> <p>Fields appear for specifying private insurance information.</p>  <p>2. Under Private Insurance, enter data as described in Understand the interface and data entry in it, on page 11.</p> <table border="1"> <thead> <tr> <th>Field</th><th>Information needed</th></tr> </thead> <tbody> <tr> <td>Company Name</td><td>The name of the patient's insurance company.</td></tr> <tr> <td>Subscriber ID</td><td>The patient's identification number to the insurance company.</td></tr> <tr> <td>Group Number</td><td>The identification number or name of the patient's insurance group.</td></tr> <tr> <td>Insurance Phone</td><td> The phone number of the insurance company. <div> Note: If you are not able to obtain the phone number, in the number pad on the right side of the interface, click UTO (unable to obtain). </div> </td></tr> <tr> <td>Plan Type</td><td>The type of insurance plan the patient is covered under.</td></tr> <tr> <td>Insured Name</td><td>The last (family) name, first (given) name, and middle name (if any) of the person insured by the insurance company.</td></tr> <tr> <td>Insured SSN</td><td> The Social Security Number (SSN) of the person insured by the insurance company. <div> Note: If you are not able to obtain the SSN, in the number pad on the right side of the interface, click UTO (unable to obtain). </div> </td></tr> </tbody> </table>	Field	Information needed	Company Name	The name of the patient's insurance company.	Subscriber ID	The patient's identification number to the insurance company.	Group Number	The identification number or name of the patient's insurance group.	Insurance Phone	The phone number of the insurance company. <div> Note: If you are not able to obtain the phone number, in the number pad on the right side of the interface, click UTO (unable to obtain). </div>	Plan Type	The type of insurance plan the patient is covered under.	Insured Name	The last (family) name, first (given) name, and middle name (if any) of the person insured by the insurance company.	Insured SSN	The Social Security Number (SSN) of the person insured by the insurance company. <div> Note: If you are not able to obtain the SSN, in the number pad on the right side of the interface, click UTO (unable to obtain). </div>
Field	Information needed																
Company Name	The name of the patient's insurance company.																
Subscriber ID	The patient's identification number to the insurance company.																
Group Number	The identification number or name of the patient's insurance group.																
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To do this	Do this												
	<table> <tr> <th>Field</th><th>Information needed</th></tr> <tr> <td>Insured DOB</td><td>The date of birth (DOB) of the person insured by the insurance company.</td></tr> </table>	Field	Information needed	Insured DOB	The date of birth (DOB) of the person insured by the insurance company.								
Field	Information needed												
Insured DOB	The date of birth (DOB) of the person insured by the insurance company.												
Add other payer or self-pay information	<p>1. Click Other Payer or Self Pay.</p> <p>Fields appear for specifying who is paying the medical bills for the patient.</p>  <p>2. Under Other Payer or Self Pay, enter data as described in Understand the interface and data entry in it, on page 11.</p> <table> <tr> <th>Field</th><th>Information needed</th></tr> <tr> <td>First Name</td><td>The first (given) name of the person paying the medical bills for the patient.</td></tr> <tr> <td>Last Name</td><td>The last (family) name of the person paying the medical bills for the patient.</td></tr> <tr> <td>Address</td><td>The home mailing or street address of the person paying the medical bills for the patient.</td></tr> <tr> <td>City</td><td>The patient's home city, township, or residence.</td></tr> <tr> <td></td><td> Note: If the patient lives in an unincorporated area, use the city found in the mailing address for the patient. </td></tr> </table>	Field	Information needed	First Name	The first (given) name of the person paying the medical bills for the patient.	Last Name	The last (family) name of the person paying the medical bills for the patient.	Address	The home mailing or street address of the person paying the medical bills for the patient.	City	The patient's home city, township, or residence.		Note: If the patient lives in an unincorporated area, use the city found in the mailing address for the patient.
Field	Information needed												
First Name	The first (given) name of the person paying the medical bills for the patient.												
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City	The patient's home city, township, or residence.												
	Note: If the patient lives in an unincorporated area, use the city found in the mailing address for the patient.												

To do this	Do this	
	Field	Information needed
	State	The home state, territory, or province, or District of Columbia where the person paying the medical bills for the patient resides.
	Zip	The ZIP code of residence for the person paying the medical bills for the patient. This is the numerical code assigned by the U.S. Postal Service to all U.S. jurisdictions.
	Relationship	The relationship of the patient to the primary insured person.
	Phone	<p>The home or other phone number of the person paying the medical bills for the patient.</p> <p>Note: If you are not able to obtain the phone number, in the number pad on the right side of the interface, click UTO (unable to obtain).</p>
	Next of Kin	The last (family) name, first (given) name, and middle initial (if any) of the patient's closest relative or guardian.
	Phone	<p>The home or other phone number of the patient's closest relative or guardian.</p> <p>Note: If you are not able to obtain the phone number, in the number pad on the right side of the interface, click UTO (unable to obtain).</p>
	Employer	The name of the patient's employer.
	Employer Phone	<p>The phone number of the patient's employer.</p> <p>Note: If you are not able to obtain the phone number, in the number pad on the right side of the interface, click UTO (unable to obtain).</p>
	Date of Birth	The patient's date of birth.

4. In the lower left corner of the interface, click **Submit**.

The original interface for the Insurance tab reappears, and the insurance information you entered appears in the list in the lower half of the tab.

Type	Information
Private Insurance	Company Name: Aetna Insurance Phone: UTO Insured SSN: UTO
Other Payer or Self Pay	First Name: Ludwig Last Name: Tomes Address: 12345 First St City: Raleigh State: NC Zi...

Forms

Tip: To change the information for any of the insurance types listed, select the entry, and then click **Edit Selected**. The fields for that type of insurance reappear, and you can edit the data as needed.

5. (Optional) Delete an insurance type from the list.
 - a. Select the entry you want to delete, and then click **Delete Selected**.

The **Delete Insurance Type** dialog box appears.

Delete Insurance Type ✕

Are you sure you want to delete this Insurance Type?

- b. Click **Yes**.

The insurance type you selected disappears from the list.

6. (Optional) Attach an Advanced Beneficiary Notice (ABN) form to the patient's insurance information, as described in [Attach an Advanced Beneficiary Notice \(ABN\)](#), on page 45.
7. (Optional) Attach a Physician's Certification Statement (PCS) form to the patient's insurance information, as described in [Attach a Physician's Certification Statement \(PCS\) form](#), on page 47.
8. In the lower left corner of the screen, for **Hospital Face Sheet**, select **Yes** or **No** to indicate whether or not to include a cover sheet for the health insurance documentation.

Attach an Advanced Beneficiary Notice (ABN)

An Advance Beneficiary Notice (ABN), also known as a "waiver of liability," is a notice that suppliers and other medical providers are required to give a patient when they offer services or items that they know or have reason to believe Medicare will determine to be medically unnecessary for the patient, and therefore, will not pay for.

Providers are not required to give a patient an ABN for services or items explicitly excluded from Medicare coverage (items that are never covered by Medicare even if medically necessary, such as hearing aids). In addition, ABNs only apply if the patient is in Original Medicare, not if the patient is in a Medicare private health plan (HMO, PPO or PFFS).

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
2. Click the **Patient** tab, and then click the **Insurance** sub-tab.
Fields appear for specifying the information about any insurance the patient has.
3. In the lower right corner of the interface, under **Forms**, click **ABN Form**.



The **Advanced Beneficiary Notice of Noncoverage** dialog box appears.

Advanced Beneficiary Notice of Noncoverage

View FormClose

A. Notifier: B. Patient Name: C. Identification Number

NOTE: If Medicare doesn't pay for D. below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. below.

D. Items or Services:

E. Reason Medicare May Not Pay: F. Estimated Cost:

G. Options: Check only one box. We cannot choose a box for you.

☐ OPTION 1. I want the D. listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ OPTION 2. I want the D. listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ OPTION 3. I don't want the D. listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information

Signature of patient or person acting on patient's behalf

Clear Signature

4. Fill out the fields in the form as appropriate.
5. Under **Signature of patient or person acting on patient's behalf**, have the patient or acting on the patient's behalf use the stylus, their finger, or the mouse pointer to "write" their signature in the box.

Tip: If the signature is not satisfactory, click **Clear Signature** and have the individual sign the ABN form again.

6. Click **View Form**.

The form, as it would appear if you print or fax it, appears in FH Medic.

A. Notifier:

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

Tip: You can fax an ABN to a destination or print the ABN by clicking **Fax** or **Print** at the top center and top right of the interface, respectively, and then following the prompts that appear.

7. In the upper left corner of the interface, click **Go Back**.

Attach a Physician's Certification Statement (PCS) form

A Physician's Certification Statement (PCS) is required for patients who are under the direct care of a physician and are required for scheduled and non-scheduled non-emergency ambulance transports. The physician is responsible for supervising the medical care of the patient, including reviewing the patient's program of care, ordering medications, monitoring changes in the patient's medical status, and signing and dating all orders.

Note: A PCS is not required for emergency transports or for non-scheduled, non-emergency transports of patients residing at home or in facilities where they are not under the direct care of a physician.

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

2. Click the **Patient** tab, and then click the **Insurance** sub-tab.

Fields appear for specifying the information about any insurance the patient has.

3. In the lower right corner of the interface, under **Forms**, click **PCS Form**.

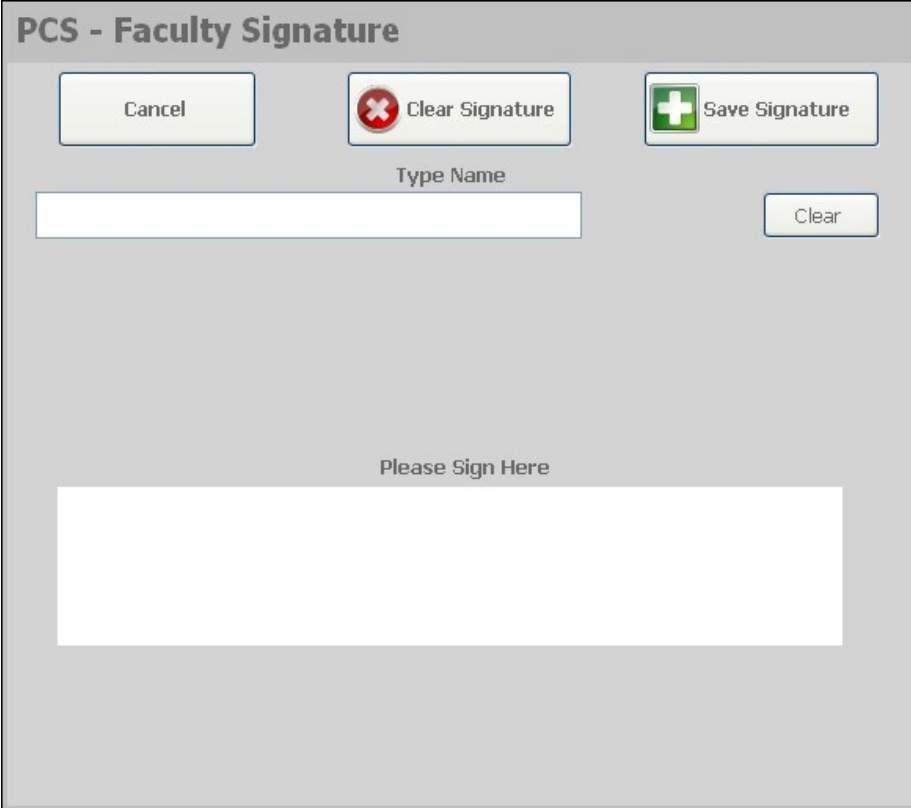


The **Physician's Certification Statement** dialog box appears.

A screenshot of the 'Physician's Certification Statement' dialog box. The dialog has a title bar with 'View Form' and 'Close' buttons. The main area contains a list of certification items, each with 'Yes' and 'No' radio buttons. Most 'No' buttons are selected. The items include: EKG monitoring required enroute, Ventilator dependent, apnea monitor, Possible intubation needed or deep Suctioning, IV monitoring or IV medications required, Actively Chemically restrained, EMTALA physician directed transfer, Suction Required enroute, Oxygen required (not applicable to prescribed O2 as a self-administered therapy), Restrained. Danger to Self or others, Orthopedic device. Halotraction: backboard, etc., Risk of falling off wheelchair or stretcher while in motion. Condition is such that patient risks injury during vehicle movement despite safetybelts, Patient Safety: Danger to Self. Behavioral/cognitive risk such that patient requires stretcher-side monitoring for safety; cannot travel by wheelchair or unattended stretcher van., Flight risk. Behavioral/cognitive risk such that patient requires attendant to assure patient does, Airway control/positioning required. Condition is such that patient requires constant airway monitoring, Isolation. Patient must be isolated from public or whose medical condition must be protected from public exposure, Patient Size. Morbid obesity which requires additional personnel or equipment to transfer., Positioning/Specialized Handling. (1) Special handling to avoid further injury (e.g. > grade 2 decubiti on buttocks); (2) Positioning in wheelchair or standard car seat inappropriate due to contratures; (3) Recent extremity fractures requiring patient to remain supine/immobile during and for period of time after transport., and Bed Confined. If no other condition applies, please describe the reason (Medical Condition) non-ambulance stretcher transport is contraindicated. At the bottom, there is a 'Facility or Hospital Facility Position' dropdown menu, and two buttons: 'Get Faculty Signature' and 'Get Patient Signature'.

4. Make selections in the form as appropriate.
5. From **Facility or Hospital Faculty Position**, select the type of faculty authorizing the ambulance transportation.
6. Click **Get Faculty Signation**.

The **PCS - Faculty Signature** dialog box appears.

The dialog box is titled "PCS - Faculty Signature". At the top, there are three buttons: "Cancel", "Clear Signature" (with a red 'X' icon), and "Save Signature" (with a green plus icon). Below these buttons is a text input field labeled "Type Name". To the right of this field is a "Clear" button. Below the "Type Name" field is a large white rectangular area labeled "Please Sign Here".

7. Click the **Type Name** field, and then use the keyboard that appears to type the name of the facility or hospital faculty who will sign the PCS.
Tip: To remove the name from **Type Name**, click **Clear** to the right of the field.
8. Under **Please Sign Here**, have the individual use the stylus, their finger, or the mouse pointer to "write" their signature in the box.
Tip: If the signature is not satisfactory, click **Clear Signature** and have the individual sign the form again.
9. Click **Save Signature**.
The **PCS - Faculty Signature** dialog box closes.
10. In the **Physician's Certification Statement** dialog box, click **Get Patient Signature**.


The **PCS - Patient Signature** dialog box appears.



The dialog box is titled "PCS - Patient Signature". It contains three buttons at the top: "Cancel", "Clear Signature" (with a red X icon), and "Save Signature" (with a green plus icon). Below these is a text input field labeled "Type Name" with a "Clear" button to its right. At the bottom, there is a large white rectangular area labeled "Please Sign Here".

11. Repeat steps 8–10 to get the patient's signature.
12. Click **View Form**.

The form, as it would appear if you print it, appears in FH Medic.



The form is titled "Physician Certification Statement" and features the FH Medic logo. It includes a "Go Back" button in the top left and a "Print" button in the top right. Below the title, there is a text box explaining Medicare coverage for non-emergency ambulance transportation. The form contains several input fields for patient information and a table for medical necessity information.

Patient Name:	Date of PCS Certification:		
Date of Birth:	Medicare Number:		
Medical Necessity Information: Please select the condition(s)/ service(s) which requires ambulance transport:			
EKG monitoring required enroute	Yes	Suctioning required enroute	Yes
Ventilator dependent, apnea monitor, Possible intubation needed or deep Suctioning	Yes	Oxygen required (not applicable to prescribed O2 as a self-administered therapy)	Yes
IV monitoring or IV medications required	Yes	Restrained: Danger to self or others	No
Actively Chemically restrained	No	Orthopedic device: Halo traction, backboard, etc.	Yes
EMTALA physician directed transfer	Yes		
Risk of falling off wheelchair or stretcher while in motion. Condition is such that patient risks injury during vehicle movement despite safety belts			No
Patient Safety: Danger to Self Behavioral / cognitive risk such that patient requires stretcher-side monitoring			No

Tip: You can print the PCS by clicking **Print** at the top right of the interface, and then following the prompts that appear.

13. In the upper left corner of the interface, click **Go Back**.

Assess the patient's situation

When you assess the patient's situation, you can record critical patient information such as the chief complaint, the onset, provocation/palliation, quality, region/radiation, severity, and time (OPQRST) of the complaint, the assessment of the patient, symptoms, and injury descriptions/locations.

Identify the chief and secondary complaints

The chief complaint is a concise statement describing the symptom, problem, or condition that is the reason for a medical encounter. A secondary complaint is a second, less severe problem with the patient, which may or may not be directly related to the chief complaint.

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

2. Click the **Situation** tab.

By default, the **Chief Complaint** sub-tab is selected, the **Primary Impression** selection button below the sub-tab is selected, and the **Medical** sub-tab under below **Primary Impression** is selected.

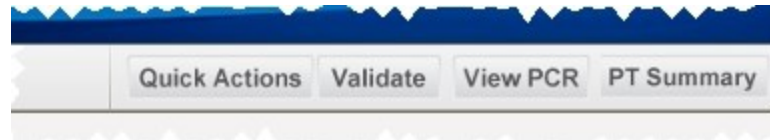
The screenshot shows the top navigation bar with tabs: Response, Patient, Situation (selected), Events, and Summary. Below this is a sub-tab bar with: Chief Complaint (selected), OPQRST, Assessment, Symptoms, Injury, and Diagram. Under Chief Complaint, there are two buttons: Primary Impression (selected) and Secondary Impression. Below these are two sub-tabs: MEDICAL (selected) and TRAUMA. Under MEDICAL, there are five buttons: Abdominal Symptoms, Cardiac (Atypical), Gastrointestinal Symptoms (Nau/Vom), OB-Gyn (Pregnancy / Labor), and Respiratory Distress.

3. Determine whether the complaint is a medical issue or a trauma (physical injury) to the patient, and then click either the **Medical** or **Trauma** sub-tab.

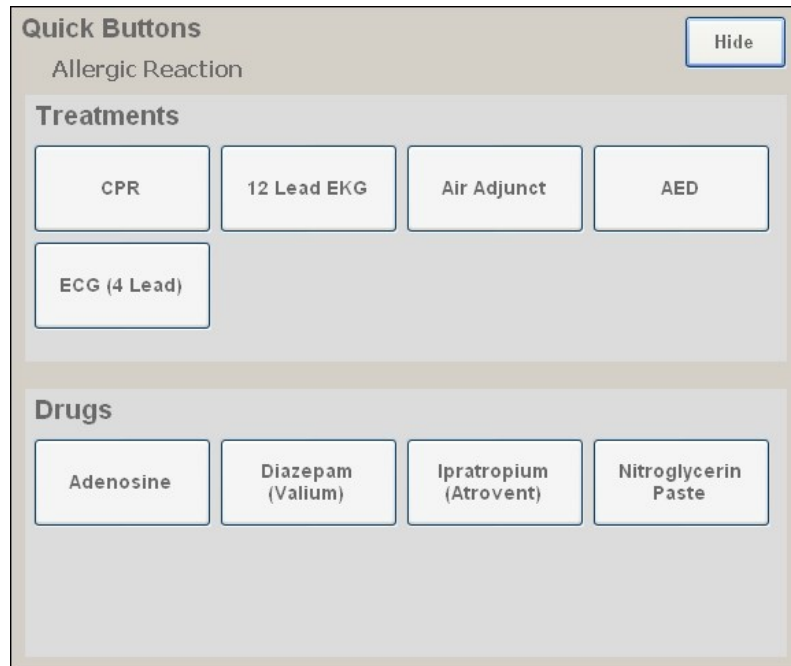
Selections for specifying the problem the emergency medical services team was called for in one or two words appear.

The first screenshot shows the Primary Impression selection screen. It has two tabs: MEDICAL and TRAUMA. Under MEDICAL, there are 20 buttons arranged in a grid: Abdominal Symptoms, Cardiac (Atypical), Gastrointestinal Symptoms (Nau/Vom), OB-Gyn (Pregnancy / Labor), Respiratory Distress, Abnormal Vital Signs, Cardiac Arrest, HAZMAT Exposure, OB-Gyn (Vaginal Hemorrhage), Seizure, Allergic Reaction, Choking / Airway, Headache, Obvious Death, Stroke / CVA, Altered Level of Consciousness, Dizziness, Hemorrhage, OD / ETOH Abuse, Syncopy, Animal Bites / Stings, Diabetic Symptoms, Hyperthermia, Other, Unconscious / Unresponsive, Back Pain, Behavioral / Psychiatric Disorder, Hypothermia, Pain, Weakness, Cardiac (Chest Pain), Environmental Exposure, OB-Gyn (Other), and Respiratory Arrest. The second screenshot shows the TRAUMA tab selected. It has 10 buttons: Trauma - Amputation, Trauma - Fracture / Dislocation, Trauma - Pain, Trauma - Assault, Trauma - GSW, Trauma - Penetrating Injury, Trauma - Blunt Injury, Trauma - Head Injury, Trauma - Respiratory Distress, Trauma - Burns, Trauma - Hemorrhage, Trauma - Stabbing, Trauma - Cardiac Arrest, Trauma - Lightning Injury, Trauma - Drowning / Near Drowning, Trauma - MVC / MCC, Trauma - Electrical Injury, Trauma - Obvious Death, Trauma - Fall, and Trauma - Other.

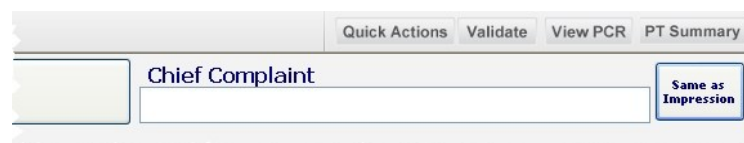
4. Click one of the selections to describe the primary problem.
Your selection appears on the **Primary Impression** button.
5. (Optional) In the upper right corner of the interface, click **Quick Actions**.



The **Quick Buttons** dialog box appears, listing action plan information such as treatment processes and medications that you may administer based on the selected primary impression.



- a. Select the treatment and/or medication that was administered to the patient.
The time is automatically recorded for that treatment or medication, and automatically added to the events log, where the patient's vitals, procedures, and medications are recorded.
- b. Click **Hide** to close the dialog box.
6. Click the **Secondary Impression** sub-tab.
7. Repeat steps 3-5 to identify the secondary impression.
8. Depending on whether or not the primary impression is the actual chief complaint, in the upper right corner of the interface, do one of the following.



Is the chief complaint the same as the primary impression?	Do this
Yes	<ul style="list-style-type: none"> Click Same as Impression. The selection listed on the Primary Impression button appears under Chief Complaint.
No	<ul style="list-style-type: none"> In Chief Complaint, type a description of the actual complaint the patient suffers.

Assess OPQRST symptoms

OPQRST is an mnemonic initialism used by medical providers to facilitate taking a patient's symptoms and history in the event of an acute illness. Each letter stands for an important line of questioning for the patient assessment. The parts of the mnemonic are: **O**nset , **P**rovocation/palliation, **Q**uality, **R**egion/Radiation, **S**everity, and **T**ime.

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

2. Click the **Situation** tab, and then click the **OPQRST** sub-tab.

Fields for gathering information related to the OPQRST symptoms appear on the left side of the interface.

Time (Duration)

Days

Hours

Minutes

Onset Date / Time

Provocation

Quality

Radiation

Severity

3. Under **Time**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Days, Hours, Minutes	The number of days, hours, and minutes that have elapsed since the patient began experiencing the complaint for this call.
Onset Date / Time	The date and time when the patient initially experienced the complaint for this call.
Provocation	A description of any movement, pressure (such as palpation) or other external factor makes the problem better or worse. This can also include whether the symptoms relieve with rest.
Quality	The patient's description of the pain (sharp, dull, crushing, burning, tearing, or some other feeling, along with the pattern, such as intermittent, constant, or throbbing).
Radiation	Where the pain is on the body and whether it radiates (extends) or moves to any other area. This can give indications for conditions such as a myocardial infarction, which can radiate through the jaw and arms. Other referred pains can provide clues to underlying medical causes.
Severity	The pain score (usually on a scale of 0 to 10). Zero is no pain and ten is the worst-possible pain.

Perform initial patient assessment

The initial patient assessment, also referred to as the primary survey, is a critical component of pre-hospital care. This assessment is the basis from which all medical and trauma care decisions are made.

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

2. Click the **Situation** tab, and then click the **Assessment** sub-tab.

An interface for adding a new patient assessment appears on the left side of the interface, and a summary of any assessment information you enter appears at the bottom of the interface. Because you may assess the patient's condition multiple times during treatment, you can record your findings for each of these assessments.

The screenshot displays a software interface for patient assessment. At the top left, there is a button labeled 'Within Normal Limits'. Below it is a large, light gray rectangular area with the text 'Add New Assessment' centered at the top. At the bottom of the interface, there is a summary table with the following structure:

Add New Assessment		Delete				
Time	Skin	Head/Face	Neck	Chest/Lungs	Left Eye	Right Eye

3. Click **Add New Assessment**.

The interface updates, and fields for entering assessment information appear on the left side of the interface. The **Date/Time of Assessment** field is selected by default, and a number pad for entering the time the patient was assessed appears on the right side of the interface.

The screenshot displays the FH Medic assessment interface. On the left, a vertical list of assessment categories is shown, with 'Date/Time of Assessment' currently selected. Below this list are buttons for 'Add New Assessment' and 'Delete'. The right side of the interface features a date/time input field and a numeric keypad. Additional buttons include 'Now', '5 min ago', '+1 min', '-1 min', 'Back', 'Clear', and 'Enter'. At the bottom, a status bar contains tabs for 'Time', 'Skin', 'Head/Face', 'Neck', 'Chest/Lungs', 'Left Eye', and 'Right Eye'. A 'Within Normal Limits' button is located in the top left corner of the main interface area.

4. For **Date/Time of Assessment**, do one of the following.
 - Click **Now** to enter the current system time on your computer.
 - Click **5 min ago** to enter the current system time on your computer, minus five minutes.
 - Click the number buttons to enter a time.
 - Adjust the time displayed with the **+1 min** or **-1 min** buttons.
5. (Optional, if all or most of the assessments you perform fall within normal limits for the patient) In the upper left corner of the interface, click **Within Normal Limits**. All the assessment fields fill in with a value of `Normal`. You can override this value for any individual field with the step below.

6. For the remaining fields, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Skin	A description of the patient's skin appearance, temperature, and moisture level, such as pale, cold, and clammy, or mottled and warm.
Head/Face	Any visible injury to the patient's head, such as a mass, lesion, or swelling, and a description of their initial facial features, such as asymmetric smile or droop.
Neck	A description of the patient's neck, such as jugular vein distention (JVD), tracheal deviation, the presence of stoma, and so forth.
Chest/Lungs	A description of the patient's chest and lung function, such as symmetrical rising/falling with each breath, the presence of subcutaneous emphysema (SCE, SE, or Sub Q air), stridor, or crepitus upon palpation.
Heart	Pulse rate, character, rhythm, and other information gathered through auscultation with a stethoscope or other cardiac monitoring systems.
LU Abdomen, LL Abdomen, RU Abdomen, RL Abdomen	An assessment of all four quadrants of the abdomen for distention, tenderness, a mass, guarding, entrance and exit wounds, evisceration, painful areas, distention, and discoloration.
GU	A description of the condition and any injuries to the patient's genital and urinary systems (kidneys, ureters, urinary bladder, and urethra).
Back Cervical, Back Thoracic, Back Lumbar/Sacral	Pain to range of motion (ROM) in the patient's back, existence of a mass, tenderness in the paraspinal muscles, muscle tightness, and tenderness in the spinous process.
RU Extremities, RL Extremities, LU Extremities, L Extremities	A description of any tenderness, swelling, weakness, deformity, contusions, abrasions, buns, bruises, wounds, blood, angulations, abnormal pulses or sensations for the patient.
Left Eye, Right Eye	An indication of whether the patient's pupils are equal and reactive to light and accommodation (PERLA), discolored, dilated (and how far), or irregular.
Mental Status	An assessment of whether the patient is alert and oriented to time, person, place, and date (A+O x 4), or whether they are confused, hallucinatory, combative, or unresponsive.
Neurological	Evaluation of the patient's nervous system, including gait, cranial muscle tone, posture, speech, tremors, or weakness on one side of the body.

List patient symptoms

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
2. Click the **Situation** tab, and then click the **Symptoms** sub-tab.
Fields for gathering information related to patient symptoms appear on the left side of the interface.

The screenshot shows a section titled "Patient Symptoms" with a list of ten categories: General, Respiratory, Cardiovascular, Neurological, Head / Neck, GI, GU / GYN, Musculoskeletal, and Metabolic. Each category is represented by a light gray rectangular button.

3. Under **Patient Symptoms**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
General	A list of general symptoms from the patient, such as chills dizziness, weakness, excessive sweating, thirst, and so forth.
Respiratory	A list of symptoms from the patient's respiratory system, such as a Cheyne-Sokes breathing pattern, stridor, coughing , sputum production, and so forth.
Cardiovascular	A list of symptoms from the patient's cardiovascular system, such as edema, numbness or tingling, cardiac arrhythmia, nausea, vomiting, chest pain, and so forth.
Neurological	A list of symptoms from the patient's neurological system, such as headache or migraine, unsteady gait, vertigo, impaired speech or vision, unilateral weakness, aphasia, and so forth.
Head / Neck	A list of symptoms from the patient's head and neck, such as ear pain, difficulty swallowing, hearing trouble, stiffness, swollen tongue, and so forth.

Field	Information needed
GI	A list of symptoms from the patient's gastrointestinal (GI) tract, such as abdominal cramping or distension, bloody stool or constipation, flatulence, heartburn, incontinence, and so forth.
GU / GYN	A list of symptoms from the patient's genitourinary and/or gynecology systems, such as contractions, pelvic pain, incontinence, and so forth.
Musculoskeletal	A list of symptoms from the patient's muscular and skeletal symptoms, such as joint pain and swelling, back pain, muscular cramping, and so forth.
Metabolic	A list of symptoms from the patient's metabolic system, such as dehydration, hyperglycemia, jaundice, rashes, hives, and so forth.

Describe patient injuries

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

2. Click the **Situation** tab, and then click the **Injury** sub-tab.

Fields for gathering information related to a patient's injury appear on the left side of the interface.

Injury

MOI

Type of Activity

Incident Location

Incident Type

Intent of Injury

Patient Exposure

3. Under **Injury**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
MOI	<p>The circumstance in which an injury occurs.</p> <p>If you click MVC (motor vehicle crash), a new set of fields appear on the right side of the interface, which are specific to this type of incident. Information on specifying data for these fields is available in Add motor vehicle crash (MVC) details, on page 60.</p> <p>If you click Fall, Burns, Stabbing, or Gunshot, a dialog box appears showing a human body, and you need to specify more details about the injury. Depending on the MOI you clicked, information on specifying these details is available in Add fall or burn injury details, on page 63, and in Add stabbing or gunshot injury details, on page 65.</p>
Type of Activity	A description of the activity the patient was involved in when the injury occurred.
Incident Location	A description of where the patient was when the injury was sustained.
Incident Type	An indication of whether or not the injury was work-related.
Intent of Injury	A description of the intent behind the injury (unintentional, assault, legal intervention, and so forth).
Patient Exposure	A list of items the patient was exposed to as causing the injury, or as a result of the injury, such as blood, chemicals, disease, body fluids, and so forth.

Add motor vehicle crash (MVC) details

1. (If you have not done so already) Begin describing the patient's injury, as outlined in [Describe patient injuries](#), on page 58.

2. Under **Injury**, click **MOI**.

The **Mechanism of Injury** (MOI) choices appear on the right side of the interface.

3. On the right side of the interface, click **MVC**.

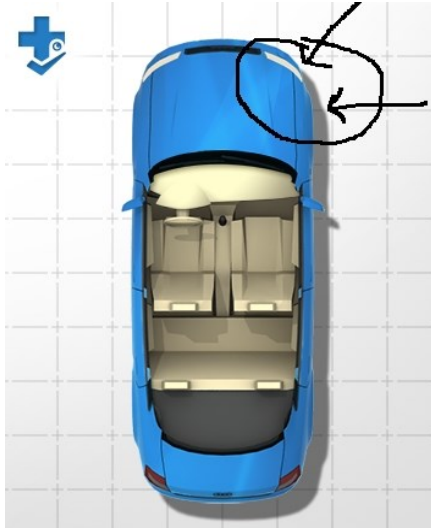
A new set of fields appear on the left side of the interface, which are specific motor vehicle crashes (MVC) and motor vehicle accidents (MVA).

The screenshot shows the 'MVC/MVA Details' section of the software interface. On the left, there is a list of fields: 'Vehicle Image', 'MVC Patient Position', 'Details', 'Safety Equipment', 'Extrication', 'Ejected from Vehicle', 'Collision', 'Airbag Deployment', and 'Vehicular Injury Indicators'. To the right of these fields is a large grid area containing a 3D model of a blue sedan. A blue medical cross icon is positioned in the top-left corner of the grid. In the top-right corner of the interface, there are buttons for 'Free Draw', 'Clear Draw', and a dropdown menu for 'Vehicle Type: Sedan'. At the bottom right of the grid, there is a 'Continue' button with a right-pointing arrow.

4. In the upper right corner of the interface, click **Vehicle Type**, and then select the type of vehicle the patient was riding in when they were injured.

This screenshot shows the same 'MVC/MVA Details' interface, but with the 'Vehicle Type' dropdown menu set to 'Motorcycle'. The 3D model on the grid is now a blue and yellow motorcycle. The 'Vehicle Type' dropdown is visible in the top-right corner, and the 'Continue' button remains at the bottom right of the grid. The top navigation bar includes 'Quick Actions', 'Validate', 'View PCR', and 'PT Summary'.

5. (Optional) In the upper right corner of the interface, click **Free Draw**, and then drag the mouse pointer to "draw" on the vehicle image, to indicate information related to the crash.



Note: You can remove any markings you draw on the vehicle image by clicking **Clear Draw**.

6. Under **Vehicle Image**, click **MVC Patient Position**.

A white X in a red circle appears by default in the driver's seat of the vehicle image, and the value for **MVC Patient Position** is automatically set to the driver's seat.



7. (If the patient was not in the driver's seat during the crash) Click the vehicle image, on the seat the patient occupied during the crash.

The position marker on the vehicle image updates accordingly, as does the value for **MVC Patient Position**.



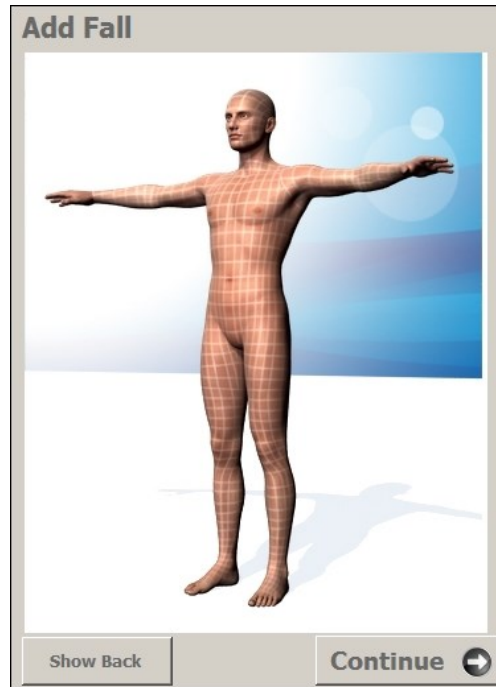
8. Under **Details**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Safety Equipment	A list of any passenger protection restraints, breathing apparatus, flotation devices, or protective equipment employed during the crash.
Extrication	An indication of whether or not the patient had to be removed from the vehicle by bystanders or emergency personnel.
Ejected from Vehicle	An indication of whether or not the patient was ejected from the vehicle during the crash.
Collision	A list of locations where the vehicle was impacted during the crash.

9. Click **Continue** to return to entering information about the patient injuries.

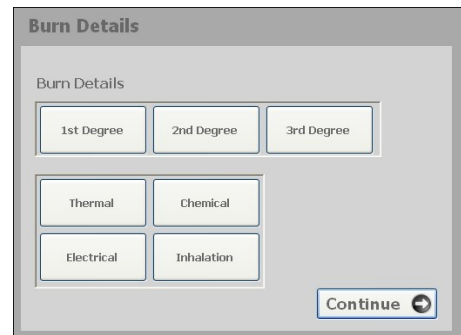
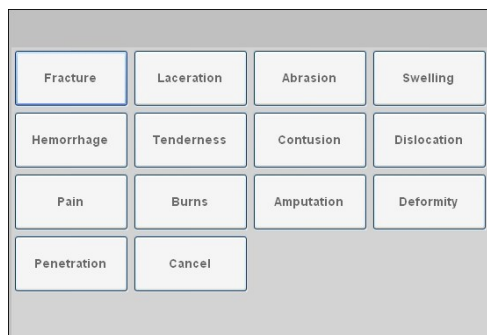
Add fall or burn injury details

1. (If you have not done so already) Begin describing the patient's injury, as outlined in [Describe patient injuries](#), on page 58.
2. Under **Injury**, click **MOI**.
The **Mechanism of Injury** (MOI) choices appear on the right side of the interface.
3. On the right side of the interface, click **Fall** or **Burns**.
The **Add Fall** or **Add Burns** dialog box appears, showing a human body.



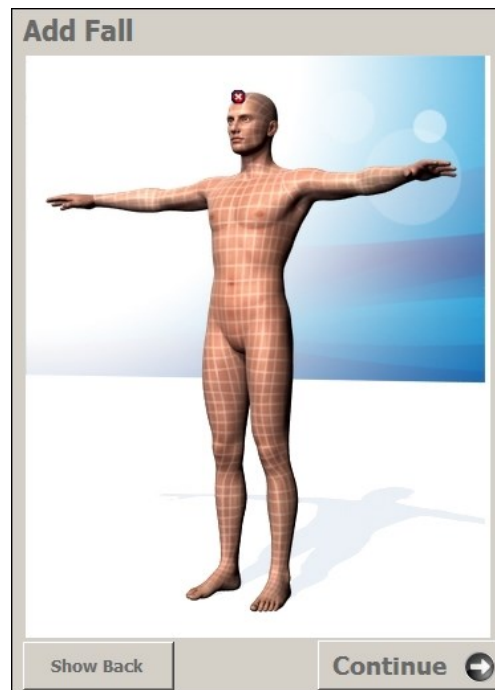
Tip: To access the back of the body in the dialog box, click **Show Back**.

4. Click a point of injury on the body in the dialog box.
A dialog box of injury descriptions appears. The list of descriptions will vary, depending on whether you are adding details about a fall or a burn.



5. Click a description of the injury at the point you clicked on the human body diagram.
Tip: If you are adding burn details, you also need to click **Continue**.

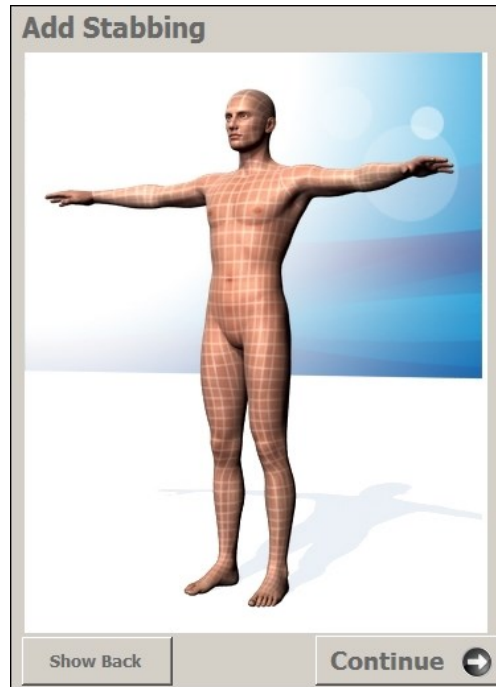
A white X in a red circle appears on the human body diagram at the point you clicked.



6. Repeat steps 4–5 for each injury you need to indicate and describe for the patient.
7. Click **Continue** to close the human body diagram dialog box, and return to entering information about the patient injuries.

Add stabbing or gunshot injury details

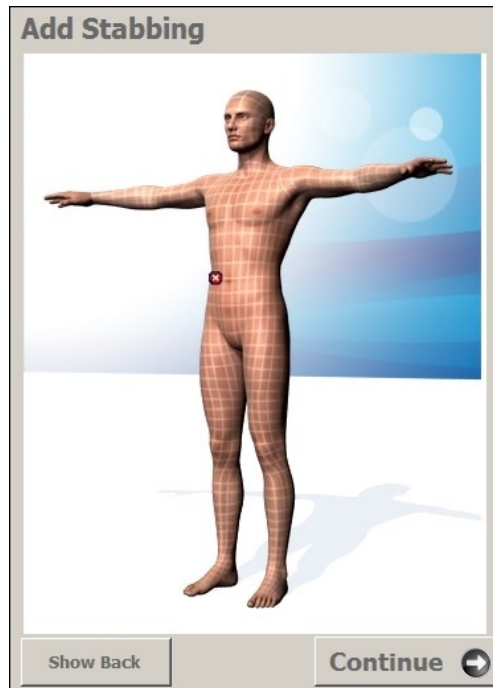
1. (If you have not done so already) Begin describing the patient's injury, as outlined in [Describe patient injuries](#), on page 58.
2. Under **Injury**, click **MOI**.
The **Mechanism of Injury** (MOI) choices appear on the right side of the interface.
3. On the right side of the interface, click **Stabbing** or **Gunshot**.
The **Add Stabbing** or **Add Gunshot** dialog box appears, showing a human body.



Tip: To access the back of the body in the dialog box, click **Show Back**.

4. Click a point of injury on the body in the dialog box.

A white X in a red circle appears on the human body diagram at the point you clicked.



5. Repeat steps 3–4 for each injury you need to indicate on the patient.
6. Click **Continue** to close the human body diagram dialog box, and return to entering information about the patient injuries.

Work with the injury summary

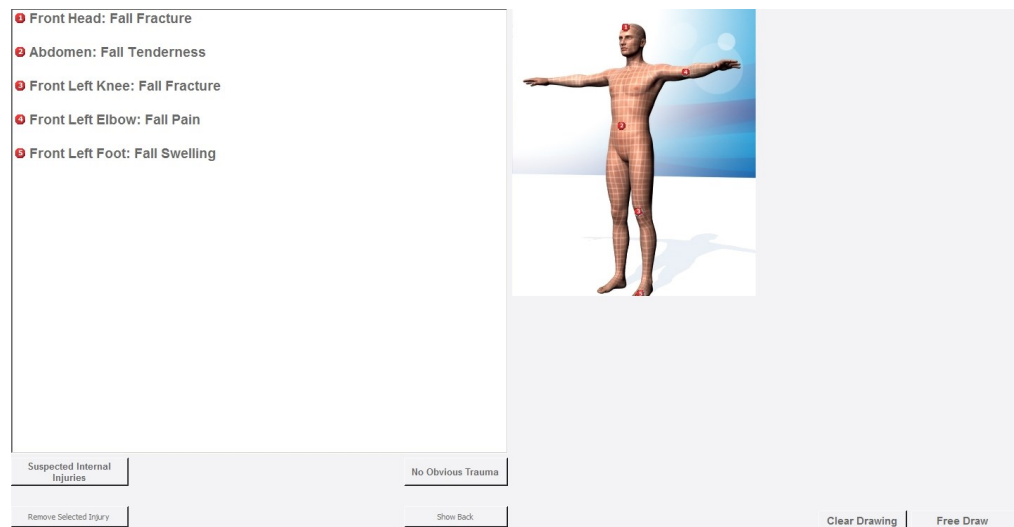
1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

2. Click the **Situation** tab, and then click the **Diagram** sub-tab.

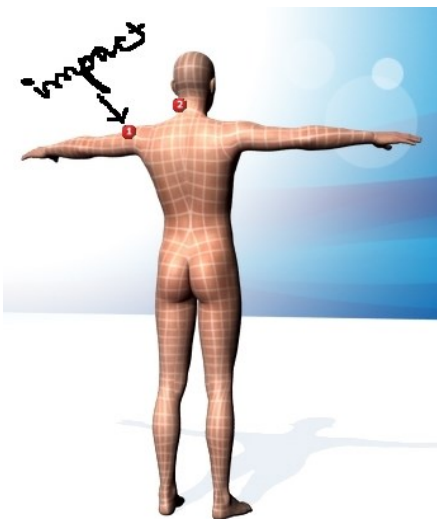
A summary of injury information entered when you described the patient's information appears. A numbered list of the injuries you entered on the **Injury** tab appears on the left side of the interface, and a human body diagram appears on the right side of the interface, with numbered markers corresponding to the list on the left.

Information on entering injury data is available in [Describe patient injuries](#), on page 58.



3. Do any of the following.

To do this	Do this
View injury markers on the other side of the body	<ul style="list-style-type: none"> At the bottom of the interface, click Show Back. The human body diagram changes to show the back of the body, and the label on the button updates to Show Front. To return to the front view of the body, click Show Front.
Indicate suspected internal injuries	<ul style="list-style-type: none"> In the lower left corner of the interface, click Suspected Internal Injuries. A new entry for internal injuries appears at the bottom of the list.
Remove an injury	<ol style="list-style-type: none"> 1. In the injury list on the left, select the injury you want to remove. 2. In the lower left corner of the interface, click Remove Selected Injury. The injury disappears from the list.
Draw on the body diagram	<ul style="list-style-type: none"> In the lower right corner of the interface, click Free Draw, and then drag the mouse pointer to "draw" on the human body dia-

To do this	Do this																
	<p>gram, to indicate information related to the injuries.</p> <div></div> <div><p>Note: You can remove any markings you draw on the body diagram by clicking Clear Drawing.</p></div>																
Add an injury	<div><div><p>1. Click the human body diagram at the location you want to add an injury.</p><p>A dialog box of injury descriptions appears. The list of descriptions will vary, depending on whether you are adding details about a fall or a burn.</p><div><div>Front Right Upper Leg: Select injury type...</div><table><tr><td>Fracture</td><td>Laceration</td><td>Abrasion</td><td>Swelling</td></tr><tr><td>Hemorrhage</td><td>Tenderness</td><td>Contusion</td><td>Dislocation</td></tr><tr><td>Pain</td><td>Burns</td><td>Amputation</td><td>Deformity</td></tr><tr><td>Penetration</td><td>Cancel</td><td></td><td></td></tr></table></div></div><p>2. Click the button corresponding to the injury you want to add to the human body diagram.</p><p>A new injury marker appears on the body diagram, and a corresponding new entry appears in the injury list on the left.</p></div>	Fracture	Laceration	Abrasion	Swelling	Hemorrhage	Tenderness	Contusion	Dislocation	Pain	Burns	Amputation	Deformity	Penetration	Cancel		
Fracture	Laceration	Abrasion	Swelling														
Hemorrhage	Tenderness	Contusion	Dislocation														
Pain	Burns	Amputation	Deformity														
Penetration	Cancel																

Document treatments and vitals data

You can document the treatments administered to the patient during the course of those treatments.

Record treatments to the patient

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

2. Click the **Events** tab, and then click the **Treatments** sub-tab.

A list of possible treatments appears.

The screenshot shows a software interface with two tabs at the top: 'Treatments' (which is selected and highlighted in orange) and 'Supplies'. Below the tabs is a grid of buttons for selecting treatments. The buttons are arranged in three rows and ten columns. The first row contains: Ventilation, Clear Airway, Oxygen Adminis, Intubation, TCP, EtCO2 monitoring, Chest Decompression, IV, Medication Administration, and Cardioversion / Defibrillation. The second row contains: IO, CPR, Spinal Immobilization, Splint, Restraint, Bandage, Traction Splint, Obstetrical Delivery, 12 Lead EKG, and CPAP. The third row contains: Alleged or Suspected Abuse or, Thermal Treatments, Air Adjunct, AED, and Field Termination. Below the grid is a large empty rectangular area. At the bottom of the interface, there is a horizontal scroll bar with a left arrow and a right arrow.

3. Click the button for the treatment administered to the patient.
Fields for gathering information related to the treatment appear on the left side of the interface.
4. Supply the necessary information for the treatment you selected.
 - [Ventilate the patient](#), on page 71
 - [Clear the patient's airway](#), on page 72
 - [Administer oxygen to the patient](#), on page 73
 - [Intubate the patient](#), on page 74
 - [Administer transcutaneous pacing \(TCP\) to the patient](#), on page 76
 - [Monitor the EtCO2 level of the patient](#), on page 77
 - [Decompress the patient's chest](#), on page 78
 - [Provide IV \(intravenous\) fluids to the patient](#), on page 79
 - [Administer medication to the patient](#), on page 81
 - [Perform cardioversion or defibrillation on the patient](#), on page 82

- **Perform IO (intraosseous infusion) on the patient**, on page 83
- **Perform CPR (cardiopulmonary resuscitation) on the patient**, on page 84
- **Immobilize the patient's spine**, on page 85
- **Apply a splint to the patient**, on page 86
- **Restrain the patient**, on page 87
- **Apply bandages to the patient**, on page 88
- **Apply a traction splint to the patient**, on page 89
- **Perform an obstetrical delivery for the patient**, on page 90
- **Perform a 12-lead EKG (electrocardiography) on a patient**, on page 92
- **Employ a CPAP (continuous positive airway pressure) treatment**, on page 93
- **Document alleged or suspected abuse or neglect**, on page 94
- **Apply thermal treatments to the patient**, on page 95
- **Use an air adjunct device on a patient**, on page 96
- **Apply an AED (automated external defibrillator) to a patient**, on page 97
- **Document field termination for a patient**, on page 98
- **Contact medical control for a patient**, on page 99
- **Perform a 4-lead ECG (electrocardiography) on a patient**, on page 100
- **Use a medical alert for a patient**, on page 101

Ventilate the patient

1. (If you have not done so already) Do the following.
 - a. Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - b. Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.
2. Click **Ventilation**.
Fields for gathering information related to the treatment appear on the left side of the interface.

3. Under **Ventilation**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
Type	The type of bag valve mask used in the treatment (adult, pediatric, or infant).
Rate (Breaths)	The number of breaths administered per minute to the patient.
O2 Flow	The rate at which oxygen flows into the patient through the ventilator.
Performed By	The person who performed the treatment.
Notes	Any additional information related to the treatment.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

4. Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Clear the patient's airway

1. (If you have not done so already) Do the following.
 - a. Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - b. Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.

2. Click **Clear Airway**.

Fields for gathering information related to the treatment appear on the left side of the interface.

3. Under **Clear Airway**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
Method	The manner in which the airway was cleared of obstruction.
Performed By	The person who performed the treatment.
Notes	Any additional information related to the treatment.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

4. Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Administer oxygen to the patient

1. (If you have not done so already) Do the following.
 - a. Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

- b. Click the **Events** tab, and then click the **Treatments** sub-tab.

The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.

2. Click **Oxygen Adminis.**

Fields for gathering information related to the treatment appear on the left side of the interface.

3. Under **Oxygen Adminis**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
Type	An indication of how the oxygen was administered (with a mask, a nebulizer, a nasal cannula, and so forth).
Rate (LPM)	The number of liters per minute (LPM) through the oxygen device's flowmeter.
Performed By	The person who performed the treatment.
Notes	Any additional information related to the treatment.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

4. Click **Submit** to save the treatment information you entered.

The **Treatments** tab reappears.

Intubate the patient

1. (If you have not done so already) Do the following.
 - a. Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - b. Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.

2. Click **Intubation**.

Fields for gathering information related to the treatment appear on the left side of the interface.

3. Under **Intubation**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
Type	The type of intubation performed (endotracheal, nasotracheal, and so forth).
Technique	The intubation technique used (standard, blind, digital, and so forth).

Field	Information needed
Successful	An indication of whether or not the intubation was successful.
Attempts	The number of attempts made at intubating the patient.
Size	The size of the tube inserted during the intubation.
Tube Depth	The depth to which the tube was inserted.
Location	Where the intubation tube was inserted.
ETCO2	The end-tidal carbon dioxide (EtCO2) level in the patient's respiration.
Checks	A list of the checks performed on the patient, to verify that the intubation is working as expected.
Tube Secured	An indication of how the tube is secured in position.
Performed By	The person who performed the treatment.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

- Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Administer transcutaneous pacing (TCP) to the patient

Transcutaneous pacing (TCP) is for temporary management of symptomatic bradycardia, including heart blocks (adults/adolescents and children with a heart rate less than 60 beats per minute).

1. (If you have not done so already) Do the following.
 - a. Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - b. Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.
2. Click **TCP**.

Fields for gathering information related to the treatment appear on the left side of the interface.

3. Under **TCP**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
Rate	The pacing rate used for the TCP device.
mA	The amount of current delivered until electrical and mechanical capture is achieved.
Capture	An indication of whether electrical and mechanical capture is achieved, as demonstrated by palpable pulses that correspond to electrical pacing spikes (maximum 120 mA).
Performed By	The person who performed the treatment.
Notes	Any additional information related to the treatment.

Field	Information needed
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

4. Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Monitor the EtCO2 level of the patient

EtCO2 is the end-tidal carbon dioxide level in the patient's respiration.

1. (If you have not done so already) Do the following.
 - a. Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - b. Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.
2. Click **EtCO2 monitoring**.

Fields for gathering information related to the treatment appear on the left side of the interface.

3. Under **EtCO2 monitoring**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
ETCO2	The end-tidal carbon dioxide (EtCO2) level in the patient's respiration.
Type	The type of tube used while monitoring the EtCO2 level, such as a nasal tube or endotracheal tube.

Field	Information needed
Performed By	The person who performed the treatment.
Notes	Any additional information related to the treatment.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

- Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Decompress the patient's chest

- (If you have not done so already) Do the following.
 - Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.
- Click **Chest Decompression**.

Fields for gathering information related to the treatment appear on the left side of the interface.

- Under **Chest Decompression**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
Site	Which side of the chest the decompression was performed on.
Size (gauge)	The gauge size of the needle (if used) during a chest decompression.

Field	Information needed
Performed By	The person who performed the treatment.
Notes	Any additional information related to the treatment.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

4. Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Provide IV (intravenous) fluids to the patient

1. (If you have not done so already) Do the following.
 - a. Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - b. Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.

2. Click **IV**.

Fields for gathering information related to the treatment appear on the left side of the interface.

The screenshot displays the 'Add New Treatment' window. On the left, a vertical list of fields is shown, with 'Time' highlighted in red. The main panel on the right features a numeric keypad (1-9, 0) and time-related buttons ('Now', '5 min ago', '10 min ago', '+ 1 min', '- 1 min', 'Clear', 'Enter'). The top right of the main panel is labeled 'Time'.

3. Under **IV**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
Side	An indication of the side of the body the IV needle was inserted into.
Site	A description of the location where the IV needle was inserted (hand, forearm, jugular, and so forth).
Successful	An indication of whether or not the insertion of the IV needle was successful.
Attempts	The number of attempts made in inserting the IV needle.
Size (gauge)	The gauge size of the needle used for the IV treatment.
Type	The type of fluid administered to the patient through the IV.
Rate	The drop rate of the IV, such as TKO (to keep open) or bolus (a single dose of medication).
Performed By	The person who performed the treatment.
gtts/min	The number of drops per minute of the fluid administered to the patient.
Total Volume Infused (ml)	The total volume of fluid absorbed by the patient.
Drip Set	The number of drops per minute that the patient receives through a drip set (the hypodermic needle, tubing, air chamber, and other parts needed to administer IV fluids).
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

4. Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Administer medication to the patient

1. (If you have not done so already) Do the following.
 - a. Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - b. Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.

2. Click **Medication Administration**.

Fields for gathering information related to the treatment appear on the interface.

The screenshot shows the 'Add New Treatment' window with the 'Medication Administration' tab selected. On the left, there is a list of fields: Time, Drug Name, Dose, Units, Route, Performed By, Pain Prior to Treatment, Pain after Treatment, and Prior To Arrival. On the right, there is a numeric keypad with buttons for digits 1-9, 0, and a 'Clear' button. Additionally, there are buttons for time offsets: 'Now', '+ 1 min', '5 min ago', '- 1 min', '10 min ago', and an 'Enter' button.

3. Under **Medication Administration**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the medication was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
Drug Name	The name of the medication administered to the patient.
Dose	The size of the dosage administered to the patient.
Units	The units the dose was measured in.
Route	How the medication was administered to the patient.
Performed By	The person who performed the treatment.
Pain Prior to Treatment	A rating on a scale of 1–10, of the pain the patient experienced before the medication was administered.
Pain after	A rating on a scale of 1–10, of the pain the patient experienced after

Field	Information needed
Treatment	the medication was administered.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

4. Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Perform cardioversion or defibrillation on the patient

Cardioversion is a procedure that can restore a fast or irregular heartbeat to a normal rhythm. Defibrillation is a therapeutic dose of electrical energy to an affected heart with a defibrillator.

1. (If you have not done so already) Do the following.
 - a. Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - b. Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.
2. Click **Cardioversion / Defibrillation**.

Fields for gathering information related to the treatment appear on the left side of the interface.

3. Under **Cardioversion / Defibrillation**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
Type	An indication of whether a cardioversion or defibrillation treatment was performed on the patient.

Field	Information needed
Energy	The number of Joules delivered by the medical device during the treatment.
Performed By	The person who performed the treatment.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

- Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Perform IO (intraosseous infusion) on the patient

Intraosseous infusion (IO) is the process of injecting directly into the marrow of a bone to provide a non-collapsible entry point into the systemic venous system. This technique is used to provide fluids and medication when intravenous (IV) access is not available or not feasible.

- (If you have not done so already) Do the following.
 - Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.
- Click **IO**.

Fields for gathering information related to the treatment appear on the interface.

- Under **IO**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.

Field	Information needed
Needle	The size of the needle used to inject fluid or medication into the bone marrow during the treatment.
Location	The name of the bone the fluid or medication was injected into.
Side	An indication of the side of the body the bone was in, into which fluid or medication was injected.
Performed By	The person who performed the treatment.
Notes	Any additional information related to the treatment.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

- Click **Submit** to save the treatment information you entered.

The **Treatments** tab reappears.

Perform CPR (cardiopulmonary resuscitation) on the patient

Cardiopulmonary resuscitation (CPR) is an emergency procedure attempting to restore spontaneous circulation and breathing by performing chest compressions with or without ventilation, in an effort to manually preserve intact brain function until further measures can be taken.

- (If you have not done so already) Do the following.
 - Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.
- Click **CPR**.

Fields for gathering information related to the treatment appear on the left side of the interface.

Add New Treatment

CPR

Time

Performed By

Performed By(Name)

Prior To Arrival

1

2

3

Now

+ 1 min

4

5

6

5 min ago

- 1 min

7

8

9

10 min ago

0

Clear

Enter

3. Under **CPR**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
Performed By	The person who performed the treatment (a bystander, family member, medical personnel, and so forth).
Performed By (Name)	The name of the person who performed the treatment.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

4. Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Immobilize the patient's spine

1. (If you have not done so already) Do the following.
 - a. Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - b. Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.

2. Click **Spinal Immobilization**.

Fields for gathering information related to the treatment appear on the left side of the interface.

Add New Treatment
Spinal Immobilization

Time

Type

Performed By

Notes

Prior To Arrival

Time

1

2

3

Now

+ 1 min

4

5

6

5 min ago

- 1 min

7

8

9

10 min ago

Enter

0

Clear

- Under **Spinal Immobilization**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
Type	The type of device used to immobilize the patient's spine, such as a cervical collar, a backboard, a CID, and so forth.
Performed By	The person who performed the treatment.
Notes	Any additional information related to the treatment.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

- Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Apply a splint to the patient

- (If you have not done so already) Do the following.
 - Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.
- Click **Splint**.

Add New Treatment

Time

Splint

Time

Type

Locations

Thermal Treatments

Performed By

Notes

Prior To Arrival

1

2

3

Now

+ 1 min

4

5

6

5 min ago

- 1 min

7

8

9

10 min ago

Enter

0

Clear

- Under **Splint**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
Type	The type of device used to immobilize a portion of the patient's anatomy, such as a backboard, a leg board, a CID, and so forth.
Locations	A list of the portions of the patient's anatomy that was immobilized.
Thermal Treatments	A list of hot, warm, cold, or cool devices used to treat the patient.
Performed By	The person who performed the treatment.
Notes	Any additional information related to the treatment.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

- Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Restrain the patient

- (If you have not done so already) Do the following.
 - Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.

- Click **Restraint**.

Fields for gathering information related to the treatment appear on the left side of the interface.

The screenshot displays the 'Add New Treatment' window with the 'Restraint' sub-tab selected. On the left, a sidebar contains input fields for 'Time', 'Type', 'Locations', 'Applied By', and 'Prior To Arrival'. The 'Time' field is currently highlighted. The main interface area features a numeric keypad for time selection, including buttons for digits 1-9, 0, 'Now', '5 min ago', '10 min ago', 'Clear', and 'Enter'. The top right corner of the window is labeled 'Time'.

3. Under **Restraint**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
Type	An indication of the type of restraint used on the patient (soft restraints, plastic straps, handcuffs, and so forth)
Locations	A list of the portions of the patient's anatomy that were restrained.
Applied By	The person who applied the restraints.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

4. Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Apply bandages to the patient

1. (If you have not done so already) Do the following.
 - a. Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - b. Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.
2. Click **Bandage**.

Add New Treatment

Bandage

Time

Types

Location

Performed By

Notes

Prior To Arrival

Time

1

2

3

Now

+ 1 min

4

5

6

5 min ago

- 1 min

7

8

9

10 min ago

0

Clear

Enter

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- Under **Bandage**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
Types	A list of the types of bandages applied to the patient's injuries.
Location	The location on the patient's anatomy where the bandage was applied.
Performed By	The person who performed the treatment.
Notes	Any additional information related to the treatment.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

- Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Apply a traction splint to the patient

- (If you have not done so already) Do the following.
 - Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.
- Click **Traction Splint**.

Fields for gathering information related to the treatment appear on the left side of the interface.

Add New Treatment

Traction Splint

Time

Side

Performed By

Notes

Prior To Arrival

Time

1

2

3

Now

+ 1 min

4

5

6

5 min ago

- 1 min

7

8

9

10 min ago

0

Clear

Enter

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3. Under **Traction Splint**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
Side	An indication of which side of the body was immobilized in a traction splint.
Performed By	The person who performed the treatment.
Notes	Any additional information related to the treatment.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

4. Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Perform an obstetrical delivery for the patient

1. (If you have not done so already) Do the following.
 - a. Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - b. Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.

2. Click **Obstetrical Delivery**.

Fields for gathering information related to the treatment appear on the left side of the interface.

Add New Treatment

Obstetrical Delivery

Time

Delivery

Complications

APGAR 1 MINUTE

APGAR 5 Minute

Performed By

Notes

Prior To Arrival

Time

1

2

3

4

5

6

7

8

9

Now

5 min ago

10 min ago

Clear

+ 1 min

- 1 min

Enter

3. Under **Obstetrical Delivery**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
Delivery	A list of the procedures that occurred during the birth of the infant.
Complications	A list of the delivery complications occurred during the birth.
APGAR 1 Minute	The APGAR rating (Appearance, Pulse, Grimace, Activity, Respiration) of the infant one minute after delivery.
APGAR 5 minutes	The APGAR rating of the infant five minutes after delivery.
Performed By	The person who performed the treatment.
Notes	Any additional information related to the treatment.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

4. Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Perform a 12-lead EKG (electrocardiography) on a patient

1. (If you have not done so already) Do the following.
 - a. Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - b. Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.

2. Click **12 Lead EKG**.

Fields for gathering information related to the treatment appear on the left side of the interface.

3. Under **12 Lead EKG**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
Interpretation	A list of the interpreted results of the electrocardiography.
Performed By	The person who performed the treatment.
Notes	Any additional information related to the treatment.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

4. Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Employ a CPAP (continuous positive airway pressure) treatment

1. (If you have not done so already) Do the following.
 - a. Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - b. Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.

2. Click **CPAP**.

Fields for gathering information related to the treatment appear on the left side of the interface.

3. Under **CPAP**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
O2 Flow Rate	The rate of oxygen being used to create the mild positive air pressure needed to keep airways open in the patient.
Performed By	The person who performed the treatment.
Notes	Any additional information related to the treatment.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

4. Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Document alleged or suspected abuse or neglect

1. (If you have not done so already) Do the following.
 - a. Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - b. Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.

2. Click **Alleged or Suspected Abuse or**.

Fields for gathering information related to the treatment appear on the left side of the interface.

3. Under **Alleged or Suspected Abuse or Neglect**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the alleged or suspected abuse or neglect was noted. By default, this value is populated with the computer's system time when you selected this treatment option.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

4. Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Apply thermal treatments to the patient

1. (If you have not done so already) Do the following.
 - a. Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - b. Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.

2. Click **Thermal Treatments**.

Fields for gathering information related to the treatment appear on the left side of the interface.

3. Under **Thermal Treatments**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
Type	A list of the hot, warming, cold, or cooling devices used on the patient.
Location	A description of where on the patient's anatomy the thermal treatments were applied.
Performed By	The person who performed the treatment.
Notes	Any additional information related to the treatment.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

4. Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Use an air adjunct device on a patient

Once an open airway has been established, an oropharyngeal or nasopharyngeal airway device may be used to facilitate an open airway. Both of these devices prevent the tongue from occluding the airway, providing an open conduit for air to pass.

1. (If you have not done so already) Do the following.
 - a. Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - b. Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.

2. Click **Air Adjunct**.

Fields for gathering information related to the treatment appear on interface.

3. Under **Air Adjunct**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
Type	An indication of whether an oropharyngeal or nasopharyngeal airway device was used.
Successful	An indication of whether the device was successfully applied to the patient.
Size	The size of the airway device.
Performed By	The person who performed the treatment.
Notes	Any additional information related to the treatment.
Prior To Arrival	Indicate whether or not actions were performed on the patient before

Field	Information needed
	you arrived on the scene.

4. Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Apply an AED (automated external defibrillator) to a patient

1. (If you have not done so already) Do the following.
 - a. Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - b. Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.

2. Click **AED**.

Fields for gathering information related to the treatment appear on the left side of the interface.

3. Under **AED**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
Performed By	The person who performed the treatment (bystander, family member, medical personnel, and so forth).
Performed By (Name)	The name of the person who performed the person.
Number of Shocks	The number of times the AED was used to shock the patient.

Field	Information needed
Notes	Any additional information related to the treatment.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

4. Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Document field termination for a patient

Field termination is the cessation of treatments to the patient, when such as signs of obvious death, obvious mortal wounds and vital organ destruction, and resuscitation efforts would endanger responders are apparent.

1. (If you have not done so already) Do the following.
 - a. Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - b. Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.
2. Click **Field Termination**.

Fields for gathering information related to the treatment appear on the left side of the interface.

3. Under **Field Termination**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
Reason for Ter-	A list of the reasons the treatments in the field were ended, such as

Field	Information needed
mination	signs of obvious death, obvious mortal wounds and vital organ destruction, and resuscitation efforts would endanger responders.
Performed By	The name of the person who determined that treatments in the field should end.
Notes	Any additional information related to the treatment.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

- Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Contact medical control for a patient

- (If you have not done so already) Do the following.
 - Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.
- Click **Contacted Medical Control**.
Fields for gathering information related to the treatment appear on the left side of the interface.

- Under **Contacted Medical Control**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.

Field	Information needed
Performed By	The name of the person who obtained medical control (also known as medical direction) to gain approval for certain treatments or guidance in performing a treatment.
Physician Name	The name of the physician who granted approval or provided guidance to the medic in the field.
Notes	Any additional information related to the treatment.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

- Click **Submit** to save the treatment information you entered.

The **Treatments** tab reappears.

Perform a 4-lead ECG (electrocardiography) on a patient

- (If you have not done so already) Do the following.
 - Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.
- Click **ECG (4 Lead)**.

Fields for gathering information related to the treatment appear on the left side of the interface.

- Under **ECG (4 Lead)**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you

Field	Information needed
	selected this treatment option.
Performed By	The name of the person who obtained medical control (also known as medical direction) to gain approval for certain treatments or guidance in performing a treatment.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

- Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Use a medical alert for a patient

- (If you have not done so already) Do the following.
 - Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.
By default, the **Response** tab and **Incident Information** sub-tab are selected.
 - Click the **Events** tab, and then click the **Treatments** sub-tab.
The **Treatments** and **Supplies** sub-tabs appear. The **Treatments** sub-tab is selected by default, displaying a list of possible treatments.

- Click **Alerts**.

Fields for gathering information related to the treatment appear on the left side of the interface.

The screenshot shows the 'Add New Treatment' interface. On the left, under the 'Alerts' section, there are four input fields: 'Time' (highlighted with a blue bar), 'Type', 'Performed By', and 'Prior To Arrival'. On the right, there is a numeric keypad for selecting time. The keypad includes buttons for digits 1-9, 0, and a 'Clear' button. Additionally, there are buttons for 'Now', '+ 1 min', '5 min ago', '- 1 min', '10 min ago', and an 'Enter' button. The 'Time' field is currently empty, and the 'Now' button is highlighted.

- Under **ECG (4 Lead)**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Time	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
Type	The type of alert that was activated to obtain medical assistance.

Field	Information needed
Performed By	The name of the person who activated the alert.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

- Click **Submit** to save the treatment information you entered.
The **Treatments** tab reappears.

Record vitals data

Note: If vitals data was recorded on an EKG device, you can import the data into FH Medic instead of entering the data manually. Information on importing the data is available in [Import vitals data from an EKG device](#), on page 106.

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

2. Click the **Events** tab, and then click the **Vitals** sub-tab.

Fields for gathering information related to the treatment appear on the left side of the interface, and a summary of the vitals information you enter appears at the bottom of the interface. Because you may assess the patient's vitals multiple times during treatment, you can record the vitals data for each of these assessments.

Note: The first time you access this screen, a new, blank vitals entry is automatically added to the vitals summary listing.

3. (If this is not the first time you accessed the **Vitals** tab) At the bottom of the interface, click **New**.

A new listing for the vitals information you will record appears at the bottom of the interface, and a blank set of fields appear on the left side of the interface.

4. Under **Vitals**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Note: (Optional) You can also add detailed information to specific patient vitals information. In the right pane, if a numerical key pad appears, the **Details** button appears in the upper right corner of the keypad.



- a. Click **Details**.

The **Details** dialog box appears.

- b. Select the detail button for the information you want to add, and then click **Continue**.

Field	Information needed
Time Taken	The time the treatment was administered to the patient. By default, this value is populated with the computer's system time when you selected this treatment option.
BP Sys	The patient's systolic blood pressure (BP).
BP Dia	The patient's diastolic blood pressure.
HR (BPM)	The patient's heart rate (HR), in beats per minute (BPM).
RR (BPM)	The patient's respiratory rate (RR), in breaths per minute (BPM).
SP02 %	The patient's blood oxygen saturation (SPO2).
ETCO2	The patient's end-tidal carbon dioxide (EtCO2) the level in the patients

Field	Information needed
CBG mg/dl	The patient's capillary blood glucose (CBG) level.
Temperature	The patient's body temperature.
Position	The patient's position, such as standing, sitting, supine, in a Fowler's position, and forth.
EKG	An indication of cardiac performance from an EKG (electrocardiography) device.
Performed By	The person who performed the treatment.
Pain Scale	The patient's description of how much pain they were experiencing, on a scale of 0 to 10.
SPCO	The patient's carboxyhemoglobin (SpCO) levels.
SPMET	The patient's methemoglobin (SpMet) levels.
Prior To Arrival	Indicate whether or not actions were performed on the patient before you arrived on the scene.

5. Under **Revised Trauma Score**, or **RTS**, enter the numerical score (from 0–12) calculated from the Glasgow coma scale, systolic blood pressure, and respiratory rate.

Note: When you fill in the necessary fields under **Vitals** and **Glasgow Coma Score**, FH Medic calculates the RTS for you.

6. Under **Glasgow Coma Score**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Motor Response	A numerical rating of the patient's ability to obey commands and responses to pain.
Verbal Response	A numerical rating of the patient's ability to comprehend and respond to questions clearly and coherently.
Eye Response	A numerical rating of the patient's ability to open their eyes spontaneously, in response to speech, or in response to pain.

Import vitals data from an EKG device

If vitals data was recorded on an EKG device, and if you connect the EKG device to the mobile computer running FH Medic, you can import the data into FH Medic.

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

2. Click the **Events** tab, and then click the **Vitals** sub-tab.

Fields for gathering information related to the treatment appear on the left side of the interface, and a summary of the vitals information you enter appears at the bottom of the interface. Because you may assess the patient's vitals multiple times during treatment, you can record the vitals data for each of these assessments.

Note: The first time you access this screen, a new, blank vitals entry is automatically added to the vitals summary listing.

Time	HR	RR	BP Sys	BP Dia	SP...	ETCO2	Glucose	Temp	Position
06:01:29									

3. At the bottom of the interface, click **Import Vitals EKG**.

The **Choose Patient Record** dialog box appears, listing imported EKG and vitals files.

Choose Patient Record Recent Cases

Time	Patient ID	Last Name
------	------------	-----------

Selected Case Information

Vitals

Select which reports to attach to PCR

Patient Name:

4. Under **Choose Patient Record**, select the name of the patient you want to import, and then click **Import Record**.

The vitals information imports as patient data, and all other records for the patient import as attachments to the patient's care record.

5. Click **Close**.

Describe the outcome of the incident

At the end of the incident, you can record information about the patient as they exit the scene, where they were sent, and any resulting alerts that EMS personnel need to deal with.

Record patient disposition information

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

2. Click the **Summary** tab, and then click the **Disposition** sub-tab.

Fields for gathering information related to the patient as they leave the scene of the incident appear.

The screenshot shows a web interface for recording patient disposition. It is organized into several sections:

- Details**: Contains fields for Outcome, Destination, Location Choice, Paramedic Choice, Priority to Destination, and Code to Destination.
- Patient Information**: Contains fields for Personal Items, Items Given To, Escorted By, and Condition on Arrival.
- Diverted**: Contains fields for Fac Diverted From, Fac Divert Time, and Reason Diverted.

3. Under **Details**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Outcome	How the incident ended, with respect to the the patient (the patient was transported, transferred, refused treatment, and so forth).
Destination	The medical facility the patient was transported to.
Location Choice	The influencing factor in choosing the medical facility the patient was transported to (the patient, the patient's family, EMS protocol, proximity, and so forth).

Field	Information needed
Priority to Destination	An indication of how important it is to transport the patient to the destination medical facility.
Code to Destination	An indication of whether lights and/or sirens were used when transporting the patient. A code of 380 Initial Lights and Sirens/Dwngrd indicates that no lights or sirens were used. A code of 2 indicates that lights, but no sirens were used, and a code of 3 indicates that both lights and sirens were used.

4. Under **Patient Information**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Personal Items	List any personal items (cell phone, cash, ring, backpack, and so forth) that belonged to the patient, and that have been collected during the incident by EMS personnel.
Items Given To	The individual the patient's personal items have been given to for safe keeping.
Escorted By	The individual who escorted the patient from the incident scene.
Condition on Arrival	The condition of the patient when they arrived at a medical facility.

5. Under **Diverted**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Fac Diverted From	The medical facility the patient was originally en route to for additional care.
Fac Divert Time	The time the patient was diverted from the original destination medical facility.
Reason Diverted	The reason the patient was diverted from the original destination medical facility.

6. Under **Air EMS**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

Field	Information needed
Air EMS Contacted	The time the air emergency service (EMS) was contacted.
Air EMS Arrival	The time the air EMS transport arrived on the scene.
Air EMS Depart	The time the air EMS transport left the scene.
Air EMS Company	The name of the air EMS company used.

7. Under **Alerts**, in **EMS Exposure**, select all infectious diseases that EMS personnel may have been exposed to during the incident.

Acquire and delete signatures

Depending on the outcome you select for a patient, the label on any button representing a required signature is red, to indicate that the signature is required.

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

2. Click the **Summary** tab, and then click the **Signatures** sub-tab.


Buttons for different types of signatures that you may need appear, and the labels on buttons representing required signatures are red.

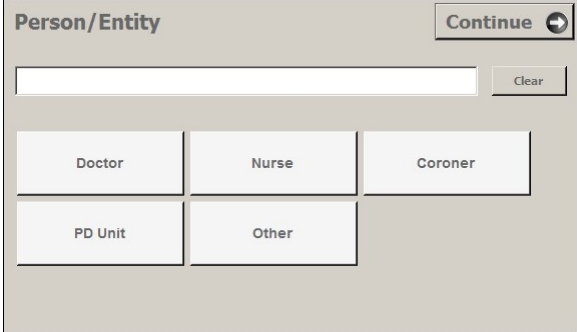
3. For each of the signatures that you need to acquire, do the following.
 - a. Click the signature type button you need.

A dialog box containing fields needed for the signature appears. This dialog box always contains **Cancel**, **Clear Signature**, **Save Signature**, **Type Name**, and **Please Sign Here**. Additional fields and read-only information may also appear, depending on the type of signature you clicked.

Example: If you click **Parent / Guardian**, the **Parent / Guardian Signature** appears, containing the additional legal information and the **Relationship to Patient** field. If you click **Patient**, the **Patient Signature** dialog box appears, containing additional legal information. If you click **Primary Medic**, the **Primary Medic Signature** dialog box appears, containing the additional **Crew Names** button.

- b. In **Type Name**, enter the name of the person who will signed the signature form.
- Tip:** If a different person than the one whose name is specified signs the form, click **Clear** to the right of the **Type Name** field, and then enter the correct name.
- c. In **Please Sign Here**, use your finger, a stylus, or a mouse to "write" your signature in the box.
- Tip:** If the person signing the form is dissatisfied with the appearance of their signature, at the top of the dialog box, click **Clear Signature**, and then ask them to sign the form again.
- d. (If additional fields appear in the dialog box) Do the following.

Signature type	Additional fields
Parent / Guardian Signature	<p>i. Read the legal information provided.</p> <p>Tip: To more easily read the legal information, to the right of the text, click Expand. The View Text dialog box appears, and displays the text in a larger font, on a white background.</p> <p>ii. Click the field for Relationship to Patient.</p> <p>The Relationship to Patient dialog box appears.</p>  <p>iii. Click the button corresponding to the signer's relationship to the patient, or in the blank field, type a relationship.</p> <p>iv. Click Continue.</p>
Patient	<p>Note: If the patient is unable or unwilling to provide the necessary signature, see Provide a signature for a patient, on page 114 instead.</p> <ul style="list-style-type: none"> Read the legal information provided. <p>Tip: To more easily read the legal information, to the right of the text, click Expand. The View Text dialog box appears, and displays the text in a larger font, on a white background.</p>
Primary Medic	<p>i. (If the name supplied in Type Name is not the name of the primary medic at the incident) Click Crew Names.</p> <p>A list of the crew members responding to the incident appears.</p>

Signature type	Additional fields
	<p>ii. Click the name of the crew member who will sign as the primary medic.</p>
Person/Entity Receiving Patient, Other	<p>i. Click the Signature Type field.</p> <p>The Person/Entity dialog box appears.</p>  <p>ii. Do one of the following.</p> <ul style="list-style-type: none"> Click the Doctor, Nurse, Coroner, PD Department, or Other buttons to quickly select the title of the person or organization (such as the police department) that received the patient. Click the blank field to the left of Clear, and use the keyboard that appears to type the title of the person or organization that received the patient. <p>The blank field to the left of Clear updates to reflect your selections.</p> <p>iii. (Optional) Click Clear to remove the selection displayed in the field to the left of Clear.</p> <p>iv. In the upper right corner of the dialog box, click Continue. The Person/Entity dialog box closes, and the signature type you specified appears under Signature Type in the Person/Entity Receiving Patient Signature dialog box.</p> <p>v. (Optional) In the Person/Entity Receiving Patient Signature dialog box, click Clear to remove the selection displayed under Signature Type.</p>
Patient Refused Transport, Patient Refused Treatment, Parent/ Guardian Refusal for Minor	<ul style="list-style-type: none"> Read the legal information provided. <p>Tip: To more easily read the legal information, to the right of the text, click Expand. The View Text dialog box appears, and displays the text in a larger font, on a white background.</p>

- e. Click **Save Signature**.

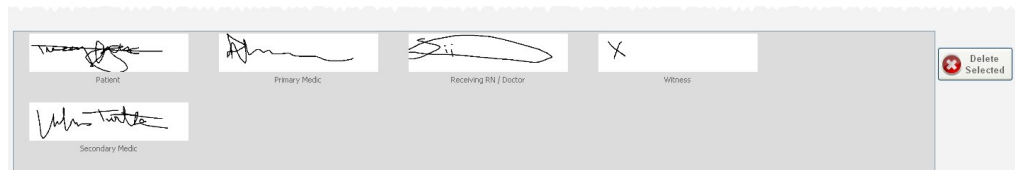
The dialog box closes, and a small image of the signature appears in the list at the bottom of the interface.

4. (Optional) Delete one of the signatures.
 - a. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab is selected.

- b. Click the **Summary** tab, and then click the **Signatures** tab.

A list of the signatures you have acquired already appears at the bottom of the interface.



- c. Select the signature in the list that you want to delete, and then click **Delete Selected**.

The signature disappears from the list.

Provide a signature for a patient

If a patient is unable or unwilling to sign forms, a medic from the incident needs to sign the **Patient Unable / Unwilling to Sign Reason** form.

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

2. Click the **Summary** tab, and then click the **Signatures** sub-tab.

Buttons for different types of signatures that you may need appear.

The screenshot shows the 'Signatures' sub-tab selected in a software interface. At the top, there are tabs for 'Disposition', 'Signatures', 'Narrative', and 'CPR'. Below these, a header reads 'Choose a Signature Type to Add...'. A grid of buttons is displayed, including 'Parent / Guardian', 'Patient', 'Primary Medic', 'Person/Entity Receiving Patient', 'Witness', 'Patient Refused Transport', 'Secondary Medic', 'Patient Refused Treatment', and 'Other'. A button for 'Parent/Guardian Refusal for Minor' is also visible. On the right side of the interface, a button labeled 'Patient Unable or Unwilling to Sign' is highlighted.


3. On the right side of the interface, click **Patient Unable or Unwilling to Sign**.

The **Patient Unable / Unwilling to Sign Reason** dialog box appears.

The screenshot shows the 'Patient Unable / Unwilling to Sign Reason' dialog box. It has a title bar with the text 'Patient Unable / Unwilling to Sign Reason' and two buttons: 'Cancel' and 'Submit'. Below the title bar is a text input field. A button labeled 'Choose Reason' is centered below the input field. The main section of the dialog is titled 'Medic Signature' and contains the text: 'My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that no responsible parties were available or willing to sign on the patient's behalf.' Below this text is a large white rectangular area for the signature. A button labeled 'Clear Signature' is located in the top right corner of the main section.

4. Click **Choose Reason**.

The **Select Reason** dialog box appears.

The image shows a dialog box titled "Select Reason...". It contains a grid of buttons for selecting reasons. The buttons are arranged in four rows and four columns, with the last row having only three buttons. The first button in the first row, "Patient Physically unable to Sign", is highlighted with a blue border. The other buttons are in a light gray box with dark gray text. The reasons listed are: Patient Physically unable to Sign, Patient Mentally unable to Sign, Patient Unwilling to Sign, Patient With Doctor, Patient Restrained, Patient Deceased, Patient Care Transferred, Patient Refused, See Narrative for Other, In Custody, Language Barrier, Minor / Child, Physical Disimpairment of Extremities, Unconscious, and Visually Impaired.

Select Reason...			
Patient Physically unable to Sign	Patient Mentally unable to Sign	Patient Unwilling to Sign	Patient With Doctor
Patient Restrained	Patient Deceased	Patient Care Transferred	Patient Refused
See Narrative for Other	In Custody	Language Barrier	Minor / Child
Physical Disimpairment of Extremities	Unconscious	Visually Impaired	

5. Click one of the reason buttons to indicate why the patient cannot or will not sign the normal form.
6. In **Medic Signature**, use your finger, a stylus, or a mouse to "write" your signature in the box.

Tip: If the person signing the form is dissatisfied with the appearance of their signature, at the top of the dialog box, click **Clear Signature**, and then ask them to sign the form again.

7. Click **Save Signature**.

The dialog box closes, and a small image of the signature appears in the list at the bottom of the interface.

Provide a medic's narrative for the incident

An automatic narrative is generated by the software, based on the information you entered in the other tabs in FH Medic. However, this automatic narrative may not capture critical information observed at the scene or through interacting with the patient, and should be supplemented with medic's narrative when necessary.

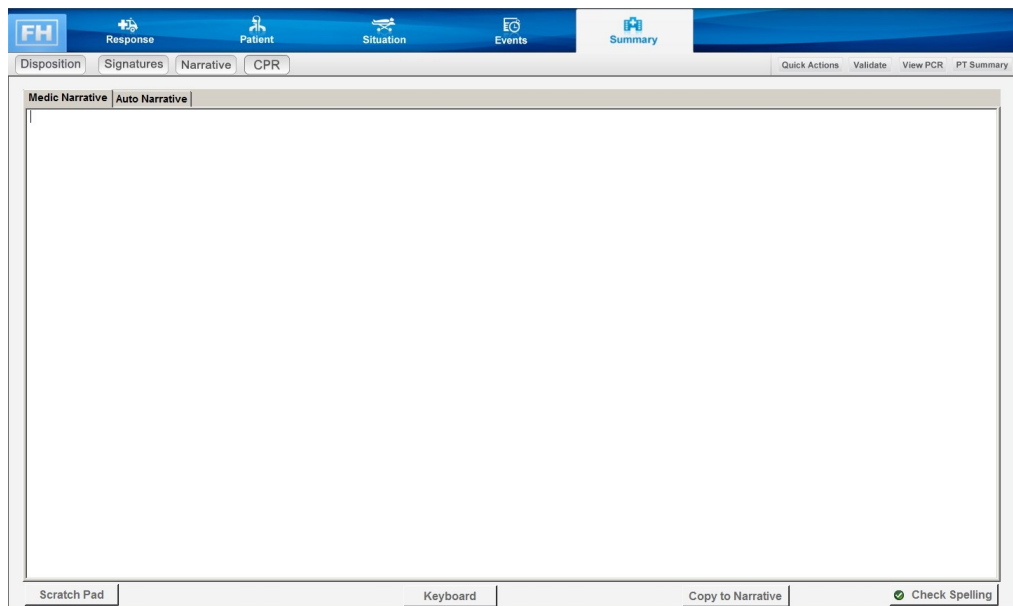
Tip: You can copy the automatic narrative to the medic's narrative, and then add to it and edit it as needed for a more detailed medic's narrative. Information on the automatic narrative is available in [View the automatic narrative for the incident](#), on page 118.

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

2. Click the **Summary** tab, and then click the **Narrative** sub-tab.

The **Medic Narrative** and **Auto Narrative** sub-tabs appear, and the **Medic Narrative** tab is selected by default.

The screenshot shows the FH Medic software interface. At the top, there is a blue header bar with the 'FH' logo and several icons labeled 'Response', 'Patient', 'Situation', 'Events', and 'Summary'. Below this is a secondary bar with tabs for 'Disposition', 'Signatures', 'Narrative', and 'CPR'. The 'Narrative' tab is active. Within the 'Narrative' tab, there are two sub-tabs: 'Medic Narrative' and 'Auto Narrative'. The 'Medic Narrative' sub-tab is selected, showing a large, empty text area for input. At the bottom of the interface, there is a toolbar with buttons for 'Scratch Pad', 'Keyboard', 'Copy to Narrative', and 'Check Spelling'.

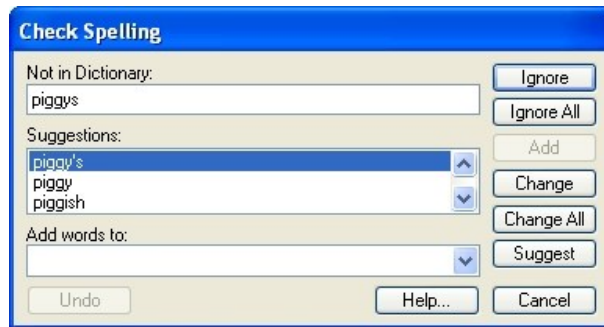
3. On the **Medic Narrative** tab, click in the large text area, or click **Keyboard** at the bottom of the tab.

A keyboard appears over the screen.

Tip: If you copied the automatic narrative to the medic narrative, you can edit the text in the medic narrative as needed.

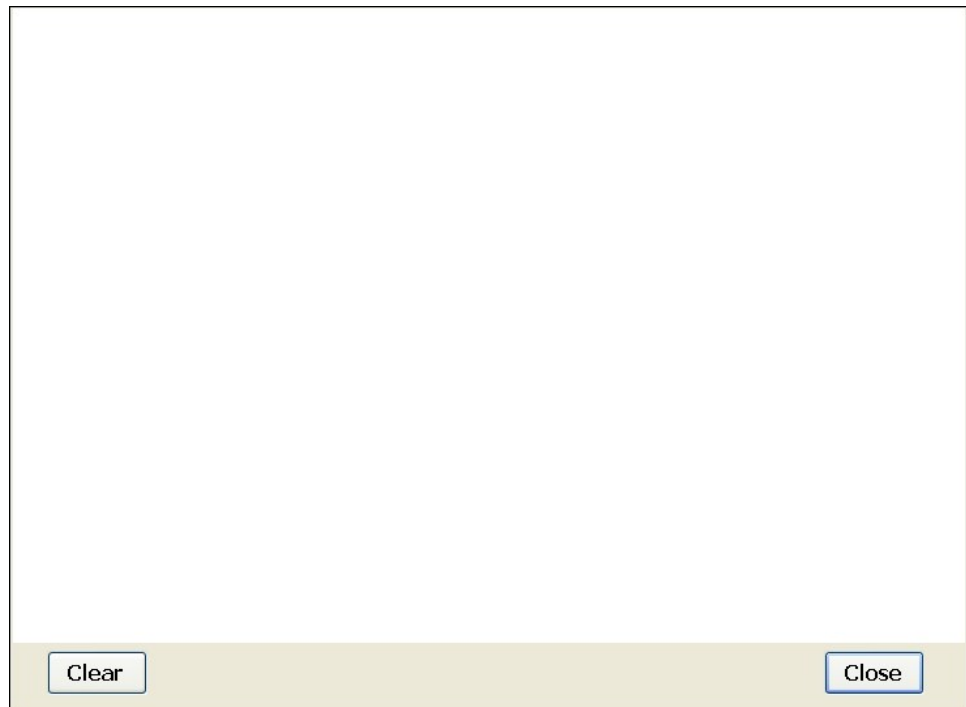
4. Use the keyboard to type a narrative describing the incident, and then click **Submit**.
5. In the lower right corner of the tab, click **Check Spelling**.

If spelling errors are found in your text, the **Check Spelling** dialog box appears.



6. (If the **Check Spelling** dialog box appears) Use the dialog box to correct any spelling errors in your text.
7. (Optional) Add hand-written notes or sketches to the incident narrative.
 - a. In the lower left corner of the tab, click **Scratch Pad**.

A blank drawing dialog box appears.



- b. Using your finger, stylus, or a mouse pointer, draw or write in the scratch pad window.

A black, two-pixel line follows your movements.

Tip: If you are unsatisfied with your results, click **Clear** to remove all lines from the scratch pad window.

- c. Click **Close**.

The notes or drawings on the scratch pad remain available until the incident is closed, and you can add to them as needed by repeating steps a–c.

View the automatic narrative for the incident

An automatic narrative is generated by the software, based on the information you entered in the other tabs in FH Medic.

Caution: The automatic narrative may not capture critical information observed at the scene or through interacting with the patient, and should be supplemented with medic's narrative when necessary. Information on adding a medic's narrative is available in [Provide a medic's narrative for the incident](#), on page 116.

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

2. Click the **Summary** tab, and then click the **Narrative** sub-tab.

The **Medic Narrative** and **Auto Narrative** sub-tabs appear, and the **Medic Narrative** sub-tab is selected by default.

3. Click the **Auto Narrative** sub-tab.

The tab displays the automatically generated narrative.

The screenshot shows the FH Medic software interface. At the top, there are tabs for Response, Patient, Situation, Events, and Summary. Below these, there are sub-tabs for Disposition, Signatures, Narrative, and CPR. The Narrative sub-tab is selected, and within it, the Auto Narrative sub-tab is active. The main text area displays an automatically generated narrative for a cardiac arrest incident on 06/17/2013. The narrative includes details about the patient (44-year-old male), medical history, treatments performed (Clear Airway, Head Tilt/Chin Lift, Chest Decompression, CPR), and the outcome (transported to Iowa Lutheran Hospital). At the bottom of the screen, there are buttons for Scratch Pad, Keyboard, Copy to Narrative, and Check Spelling.

4. (Optional) To copy the automatically generated narrative to the **Medic Narrative** tab, at the bottom of the screen, click **Copy to Narrative**.

The text on the **Auto Narrative** tab is instantly copied to the **Medic Narrative** sub-tab.

You can then edit and add to the information on the **Medic Narrative** sub-tab as needed to fill out information about the patient.

Add CPR (cardiopulmonary resuscitation) information

Cardiopulmonary resuscitation (CPR) is an emergency procedure attempting to restore spontaneous circulation and breathing by performing chest compressions, with or without ventilation, in an effort to manually preserve intact brain function until further measures can be taken.

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

2. Click the **Summary** tab, and then click the **CPR** sub-tab.

The **CPR** page appears.

3. Under **CPR**, enter data as described in [Understand the interface and data entry in it](#), on page 11.

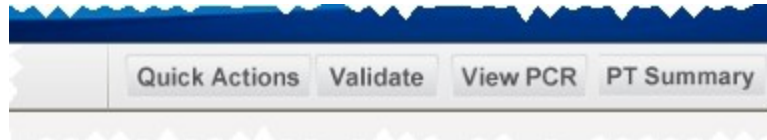
Field	Information needed
Cardiac Arrest	An indication of whether or not cardiac arrest occurred, and if one did occur, whether or not it was before EMS personnel arrived. Cardiac arrest, also known as cardiopulmonary arrest or circulatory arrest, is the cessation of normal circulation of the blood due to failure of the heart to contract effectively. A cardiac arrest is different from (but may be caused by) a heart attack, where blood flow to the muscle of the heart is impaired.
Cardiac Arrest Etiology	The apparent cause or origin of the cardiac arrest, such as an unexpected arrest, trauma, drowning electrocution, and so forth.
Resuscitation Attempted	The types of resuscitation attempted on the victim, such as ventilation, chest compressions, defibrillation, and so forth. A resuscitation attempt the act of attempting to maintain or restore life by establishing or maintaining airway (or both), breathing, and circulation.

Field	Information needed
Arrest Witnessed	An indication of whether or not the arrest was seen or heard by another person, and by whom.
First Monitored Rhythm	The first type of cardiac rhythm present when a monitor or defibrillator is attached to a patient after a cardiac arrest.
Spontaneous Circulation	An indication of whether or not the patient began breathing (more than an occasional gasp), coughing, or movement. and if spontaneous circulation did occur, whether or not it was before medical personnel arrived.
Neurological Outcome	A simple validated neurological score such as the Cerebral Performance Category (CPC) should be recorded, if available.
Time of Arrest	An indication of how long it has been since the arrest happened to the time EMS personnel arrived.
Time of Resuscitation Discontinued	The date and time the person performing CPR stopped resuscitation.
Reason CPR Discontinue	An indication of why the person performing CPR stopped.
Cardiac Rhythm	An indication of what kind of rhythm the patient's heart had after CPR had stopped.

Validate data

At any point in time with your data entry, you can validate your data to see if there are any incomplete or invalid entries that need to be addressed.

1. In the upper right corner of the interface, click **Validate**.



The **Incident Validation** screen appears, listing any items that are incomplete, or which have invalid data entered.

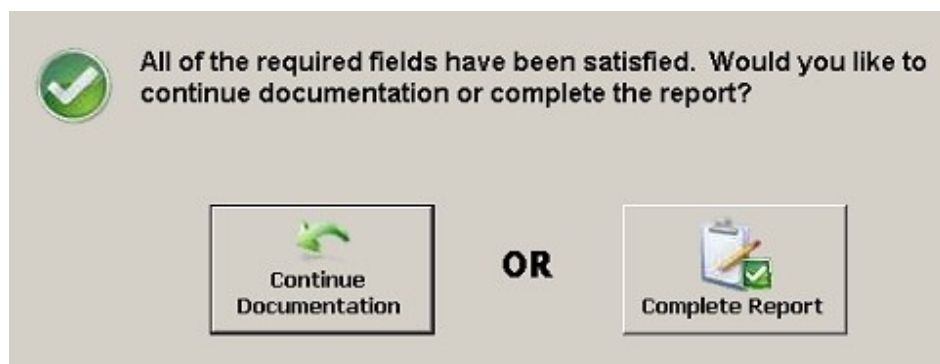
A screenshot of the 'Incident Validation' screen. The title bar shows a red exclamation mark icon and the text 'Incident Validation'. A small note on the right says 'The following fields have not been populated. Select an input to modify.' The main content area is divided into two sections: 'Required for All Incidents' and 'Treatments'. The 'Required for All Incidents' section contains a table with two columns. The first column lists various fields, and the second column lists their corresponding status or type. The 'Treatments' section contains a list of medication administration entries.

Required for All Incidents	
Code to Destination	Outcome
EMS Exposure	Outcome
Outcome	Outcome
Destination	Outcome
Location Choice	Outcome
Condition on Arrival	Outcome
Narrative	Comments
Scene Information	Incident

Treatments

- Medication Administration - Dose, Units, Ro...
- Medication Administration - Dose, Units, Ro...

2. In the list, click an item you want to complete or correct.
The tab containing the incomplete or invalid information appears.
3. Complete or correct the incomplete or invalid entry.
4. Repeat steps 1–3 until a message that all the required fields are satisfied appears.



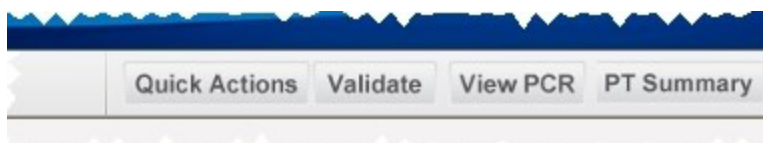
5. Depending on what you want to do, do one of the following.

To do this	Do this
Enter more data for the incident	<ul style="list-style-type: none">Click Continue Documentation. The normal interface for entering data into fields reappears.
Close the report	<ul style="list-style-type: none">Click Complete Report. On the Incidents screen, which lists all of the incidents and their current status, the status changes to Complete in the incident list, and the report is ready for review by administration on the FH Medic Cloud. The report can no longer be edited in FH Medic once it is marked as complete.

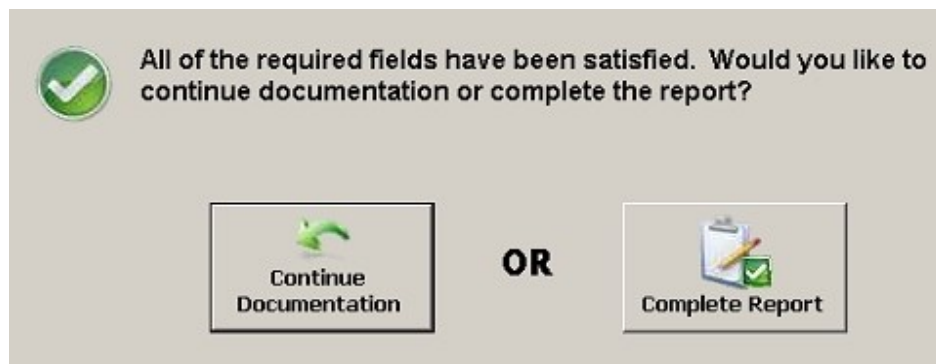
Complete an incident

When you have successfully validated your data, you can choose to complete the incident. Information on validating your data is available in [Validate data](#), on page 121.

1. In the upper right corner of the interface, click **Validate**.



If all your data is valid, a message that all the required fields are satisfied appears.



2. Click **Complete Report**.

On the **Incidents** screen, which lists all of the incidents and their current status, the status changes to Complete in the incident list, and the report is ready for review by administration on the FH Medic Cloud. The report can no longer be edited in FH Medic once it is marked as complete.

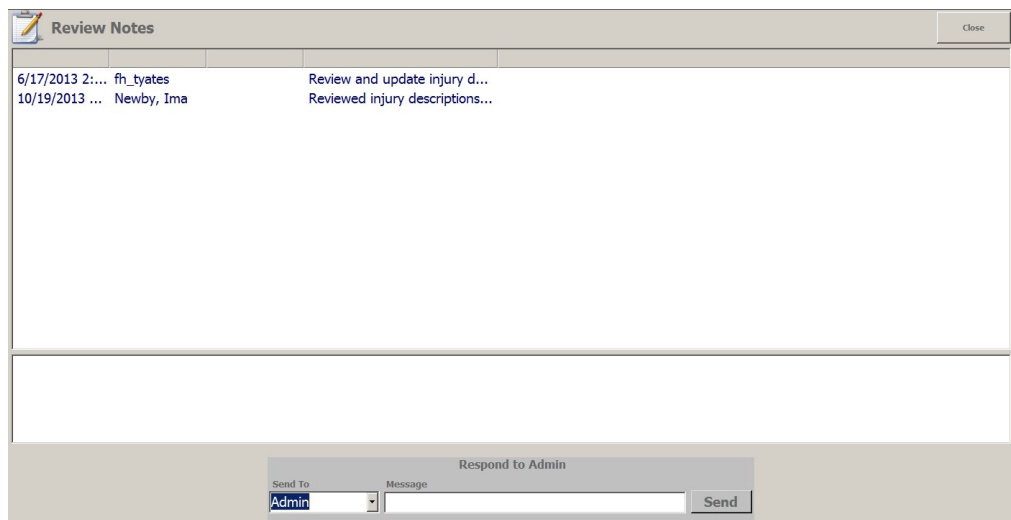
Review and respond to QA/QI notes

Quality assurance (QA) measures compliance against certain necessary standards. Quality improvement (QI) is a continuous improvement process. QA is required and normally focuses on individuals, while QI is a proactive approach to improve processes and systems. Standards and measures developed for quality assurance, can inform the quality improvement process.

When you complete an incident in FH Medic, it is reviewed by administrators on the FH Medic Cloud. Sometimes questions may arise concerning the incident, and administrators can respond with questions and review notes, which can be reviewed in FH Medic. You can also respond to those questions and notes, and view a history of the notes.

1. Choose **FH** → **Incident** → **Review Notes**.

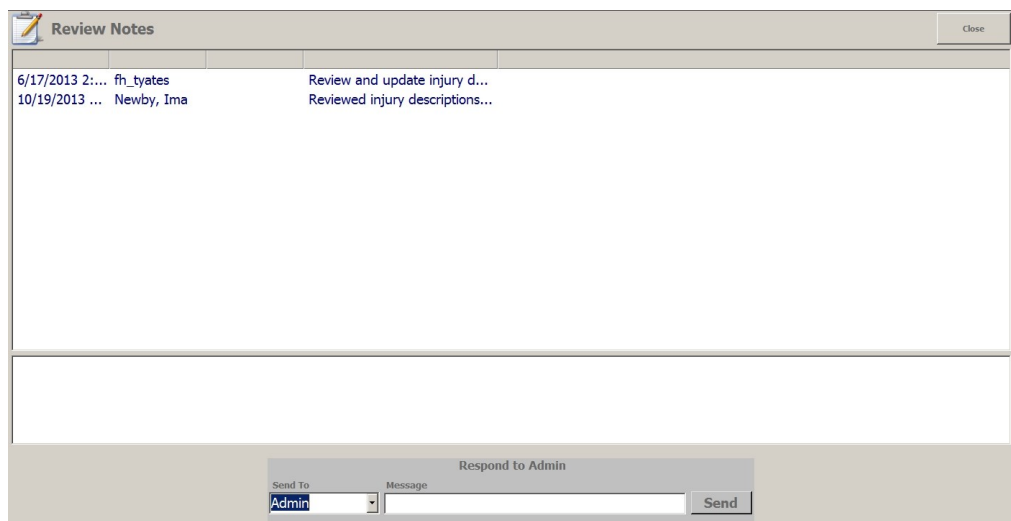
The **Review Notes** page appears, displaying any messages from the QA/QI reviewer on the FH Medic administration site.



The screenshot shows the 'Review Notes' window. It has a title bar with a pencil icon and a 'Close' button. The main area contains a table with two columns: 'Date/Time' and 'Message'. The first row shows '6/17/2013 2:...' and 'fh_tyates' with the message 'Review and update injury d...'. The second row shows '10/19/2013 ...' and 'Newby, Ima' with the message 'Reviewed injury descriptions...'. Below the table is a 'Respond to Admin' section with a 'Send To' dropdown menu set to 'Admin', a 'Message' text input field, and a 'Send' button.

2. Click an incident that has a status of **Review**.

The **Review Notes** page appears, displaying any messages from the QA/QI reviewer on the FH Medic administration site.



This screenshot is identical to the one above, showing the 'Review Notes' window with the same table of messages and the 'Respond to Admin' section at the bottom.

3. Read the notes about the changes that are needed.
4. (Optional) Under **Respond to Admin**, respond to the person who sent the message.
 - a. From **Send To**, select the person you want to send a reply to.
 - b. In **Message**, type a message, and then click **Send**.

A confirmation dialog box appears.



- c. Click **OK**.
5. In the upper right corner of the interface, click **Close**.

Amend a patient care report (PCR)

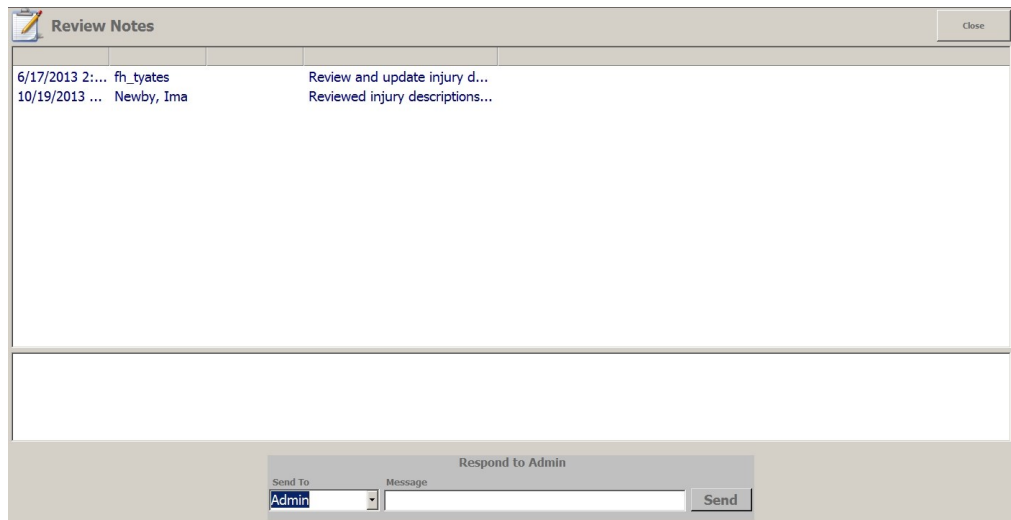
If you complete an incident, and if it is returned from the FH Medic administrators with a status of **Review**, you can amend the patient care report (PCR). FH Medic does not change the original PCR, but lists the changes at the bottom of the PCR, under the **Amendments** heading.

1. (If you are not already on the **Incidents** screen) Choose **FH → Incidents**.

The **Incidents** screen appears, listing all the available incidents.

2. Click an incident that has a status of **Review**.

The **Review Notes** page appears, displaying any messages from the QA/QI reviewer on the FH Medic administration site.



The screenshot shows a window titled "Review Notes" with a "Close" button in the top right corner. The window contains a table with two columns. The first column lists dates and user names, and the second column lists review actions.

6/17/2013 2:... fh_tyates	Review and update injury d...
10/19/2013 ... Newby, Ima	Reviewed injury descriptions...


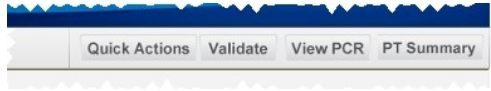
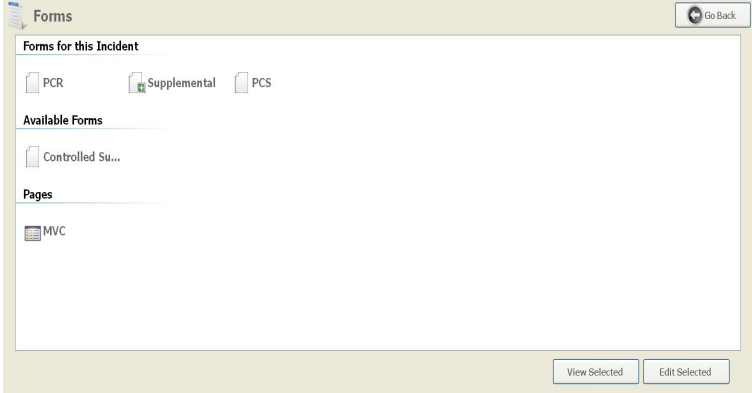
Below the table is a section titled "Respond to Admin" with a "Send To" dropdown menu (set to "Admin"), a "Message" text box, and a "Send" button.

3. Read the notes about the changes that are needed.
4. (Optional) Under **Respond to Admin**, respond to the person who sent the message.
 - a. From **Send To**, select the person you want to send a reply to.
 - b. In **Message**, type a message, and then click **Send**.

A confirmation dialog box appears.



- c. Click **OK**.
5. In the upper right corner of the interface, click **Close**.
 6. Make the changes requested in FH Medic.
 7. Depending on where you are in the FH Medic interface, do one of the following.

If you are here	Do this
At Incidents screen	<ul style="list-style-type: none"> At the bottom of the interface, click View PCR. 
On any data entry tab	<ul style="list-style-type: none"> In the upper right corner of the interface, click View PCR. 
At any screen except the Incidents screen	<p>a. Choose FH → Incident → Forms. The Forms screen appears.</p>  <p>b. Under Forms for this Incident, click PCR.</p> <p>c. In the lower right corner of the interface, click View Selected.</p>

The **Patient Care Report** screen appears.



Patient Care Report

Incident Number: 12-00010
Date of Service: 06/01/2012
Chief Complaint: Trauma - Respiratory Distress
Unit/Crew: Engine 1 - FH Guest Guest

Patient Information

Last Name:	First Name:	M/E:	DOB:	Age:
Sex:	Race:	Phone:	SSN:	DL#:
Address:	City:	State:	Zip:	County:
Insurance:	Company Name:	Phone:	Other Payer or Self Pay:	Financial Guarantor:
City:	State:	Relationship:	Guardian Phone:	Relation:

Patient Medications: Valtrex, 250mg 1x daily | glibberish, 350grams | gggggg | Acetaminophen/Codine |
Patient Allergies: Environmental - Animals, Mold, Pets, work Food - None, NO Mango, Milk or Dairy Medications - NO NKDA, ACE Inhibitors, Ciprofloxacin, Codeine
Patient History: Cardio - NO Anemia, Blood Disorder, High Cholesterol, High Blood Pressure, Palpitations, Cardiac Arrest, Arrhythmia Cancer - Prostate Neuro - Recurrent headaches GI - Digestive Problems
Genitourinary: Sexually Transmitted Disease, Urinary Tract Infections Infectious - HIV, Hepatitis C Metabolic / Endocrine - Obesity Respiratory - Asthma, Emphysema Psych - Depression, Eating Disorder, Insomnia
Womens Health: None
Patient Symptoms: General - Light Headed Respiratory - Abnormal Resp Pattern, Labored Breathing Shortness of Breath, Wheezing Neurological - Memory Problem, Flashes Head / Neck - Difficulty Swallowing

8. Scroll to the bottom of the screen and locate the **Amendments** section of the PCR.

FH Response Patient Situation Events Summary

Chief Complaint | OPCRST | Assessment | Symptoms | Injury | Diagram | Quick Actions | Validate | View PCR | PT Summary

Go Back Fax Print

View PCR View Supplemental

Outcome: Patient Transported BLS
Destination: Mary Greeley Medical Center, test, Ames, IA, 50010
Location Choice - Closest Priority to Destination - 1 Code to Destination - 1 Personal Items - Purse Items Given To - Nurse
Mileage - ~23459

Call Times

Dispatched	EnRoute	At Scene	At Patient	Depart Scene	Destination	Transfer Care	Unit Clear
13:41:07	13:44:19	13:41:15	13:25:32	13:45:37	14:05:44		14:18:57

Signatures

Primary Medic - Newby, Dma

Receiving RN / Doctor

- My signature below indicates that, at the time of service, the patient was physically or mentally incapable of signing, and that no responsible parties were available or willing to sign on the patient's behalf. Reason: Unconscious

Amendments

Time	Change Made	Modified By
6/17/2013 2:34:11 PM	Input changed from Blank to Last Edited at 6/17/2013 2:34:11 PM	Dma Newby
6/17/2013 3:09:04 PM		Dma Newby
6/17/2013 3:09:38 PM	Assessment Input changed from Normal to Not Done	Dma Newby
6/17/2013 3:09:42 PM	Assessment Input changed from Normal to Not Done	Dma Newby
6/17/2013 3:09:52 PM	Assessment Input changed from Tender Para-spinous to Pain to ROM, Tender Para-spinous	Dma Newby
6/17/2013 3:10:00 PM	Assessment Input changed from Weakness to Normal	Dma Newby
6/17/2013 3:10:05 PM		Dma Newby

Provider Info: FHMedic Support 123 Main Anywhere TX 99999 # @ #

The changes you made to the incident appear in the **Amendments** section.

Add, view, fax, and print forms

At any point in time with your data entry, you can validate your data to see if there are any incomplete or invalid entries that need to be addressed.

Add forms to the incident

1. Choose **FH** → **Incident** → **Forms**.

The **Forms** screen appears.

2. Under **Available Forms**, select the form you want to edit.

In the lower right corner of the interface, the **View Selected** button grays out, and the **Edit Selected** button is renamed **Add Form**.

3. Click **Add Form**.

The dialog box related to the form you selected appears.

Example: If you added the **Controlled Substance**, the **Controlled Substance Usage / Waste Form** dialog box appears.

4. Fill out the form with data as needed for the incident.
5. Click **Submit**.

The form disappears under **Available Forms** and appears under **Forms for this Incident**.

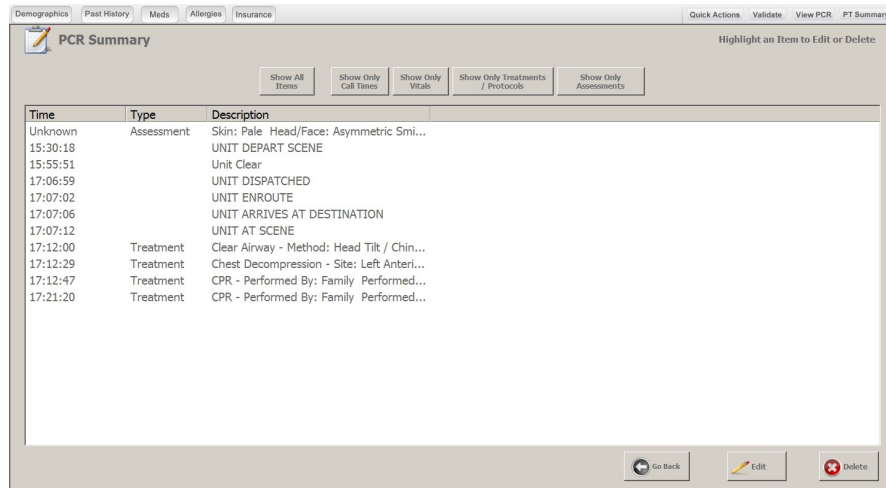
View the patient summary

1. (If you have not done so already) Add a new incident, or open an existing incident, as described in [Add or edit an incident](#), on page 7.

By default, the **Response** tab and **Incident Information** sub-tab are selected.

2. In the upper right corner of the interface, click **PT Summary**.

The **PCR Summary** screen appears, and provides an informal synopsis of all the response times, assessment information, treatments, and so forth, for the patient.



Demographics Past History Meds Allergies Insurance Quick Actions Validate View PCR PT Summary

PCR Summary Highlight an Item to Edit or Delete

Show All Items Show Only Call Times Show Only Vitals Show Only Treatments / Protocols Show Only Assessments

Time	Type	Description
Unknown	Assessment	Skin: Pale Head/Face: Asymmetric Smil...
15:30:18		UNIT DEPART SCENE
15:55:51		Unit Clear
17:06:59		UNIT DISPATCHED
17:07:02		UNIT ENROUTE
17:07:06		UNIT ARRIVES AT DESTINATION
17:07:12		UNIT AT SCENE
17:12:00	Treatment	Clear Airway - Method: Head Tilt / Chin...
17:12:29	Treatment	Chest Decompression - Site: Left Anteri...
17:12:47	Treatment	CPR - Performed By: Family Performed...
17:21:20	Treatment	CPR - Performed By: Family Performed...

Go Back Edit Delete


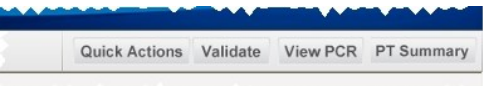
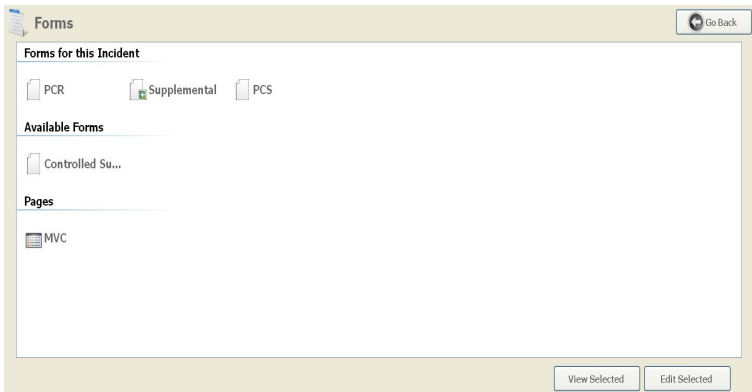
3. (Optional) Do any of the following.

To do this	Do this
Filter the information displayed	<ol style="list-style-type: none">1. Above the summary list, depending on the summary information you want to view, click one of the following buttons.<ul style="list-style-type: none">• Show Only Call Times• Show Only Vitals• Show Only Assessments• Show Only Treatments / Protocols
Edit a data item in the summary	<ol style="list-style-type: none">a. In the list of summary items, select the item you want to edit.b. In the lower right corner of the interface, click Edit. The tab or sub-tab containing the field for the data item appears.c. Change the value in the field as needed.
Delete a data item	<ol style="list-style-type: none">a. In the list of summary items, select the item you want to delete.b. In the lower right corner of the interface, click Delete. The data item disappears from the patient summary, and the values are cleared in the tab or sub-tab corresponding to the deleted item.

4. In the upper left corner of the interface, click **Go Back** to return to working in FH Medic.

View, fax, or print the patient care report (PCR)

- Depending on where you are in the FH Medic interface, do one of the following.

If you are here	Do this
At Incidents screen	<ul style="list-style-type: none"> At the bottom of the interface, click View PCR. 
On any data entry tab	<ul style="list-style-type: none"> In the upper right corner of the interface, click View PCR. 
At any screen except the Incidents screen	<ol style="list-style-type: none"> Choose FH → Incident → Forms. The Forms screen appears.  <ol style="list-style-type: none"> Under Forms for this Incident, click PCR. In the lower right corner of the interface, click View Selected.

The **Patient Care Report** screen appears.



Go Back Fax Print

View PCR View PCS View Supplemental

Patient Care Report

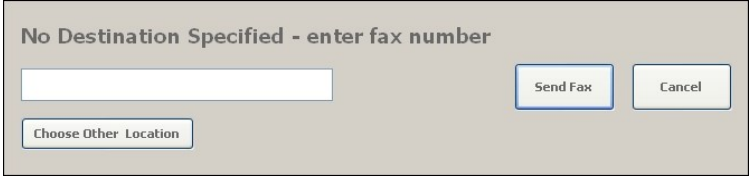
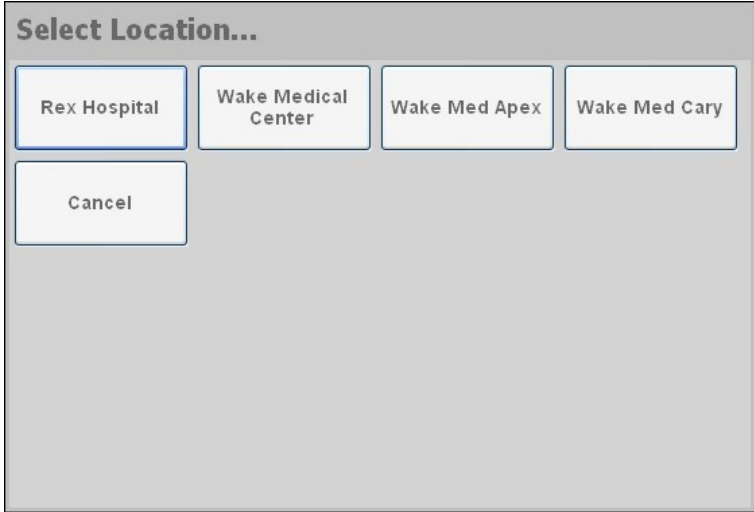
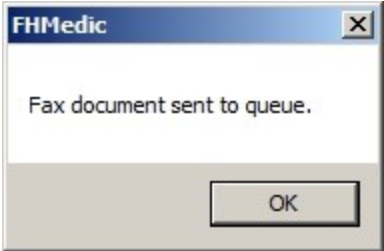
Incident Number: 12-00010
Date of Service: 06/01/2012
Chief Complaint: Trauma - Respiratory Distress
Unit/Crew: Engine 1 - FH Guest Guest

Patient Information

Last Name:	First Name:	MI: P	DOB: UTO	Age: 45
Sex: Male	Race: White	Phone: (555) 555-5555	SSN: 555-55-5555	DL#: 555555555
Address: 2444 120th St	City: Raleigh	State: NC	Zip: 27601	County: Wake
Insurance: Private Insurance - Company Name: Aetna Insurance Phone: UTO Insured SSN: UTO , Private Insurance - Company Name: Aetna Insurance Phone: UTO , Other Payer or Self Pay -	Financial Guarantor: Relation: Spouse			

Patient Medications: Valtrex, 250mg 1x daily | glibberish, 350grams | gggggg | Acetaminophen/Codine |
Patient Allergies: Environmental - Animals, Mold, Pets, work Food - None, NO Mango, Milk or Dairy **Medications** - NO NKDA, ACE Inhibitors, Ciprofloxacin, Codine
Patient History: Cardio - NO Anemia, Blood Disorder, High Cholesterol, High Blood Pressure, Palpitations, Cardiac Arrest, Arrhythmia **Cancer** - Prostate **Neuro** - Recurrent headaches **GI** - Digestive Problems
Genitourinary - Sexually Transmitted Disease, Urinary Tract Infections **Infectious** - HIV, Hepatitis C **Metabolic / Endocrine** - Obesity **Respiratory** - Asthma, Emphysema **Psych** - Depression, Eating Disorder, Insomnia
Womens Health - None
Patient Symptoms: General - Light Headed **Respiratory** - Abnormal Resp Pattern, Unforced Breathing, Shortness of Breath, Wheezing **Neurological** - Memory Problem, Vision Head / Neck - Difficulty Swallowing

2. (Optional) Do any of the following.

To do this	Do this
Fax the PCR to a person or facility	<p>a. In the center of the top of the interface, click Fax.</p> <p>The No Destination Specified - enter fax number dialog box appears.</p>  <p>b. Click Choose Other Location.</p> <p>The Select Location dialog box appears. If any fax numbers are already defined in FH Medic, a list of them appears in the dialog box.</p>  <p>c. (If the fax number you need is listed) Click the pre-defined fax number.</p> <p>d. (If the fax number you need is not listed) In the blank field, type the number of the fax machine to send the PCR to.</p> <p>e. Click Send Fax.</p> <p>A confirmation message dialog box appears.</p> 


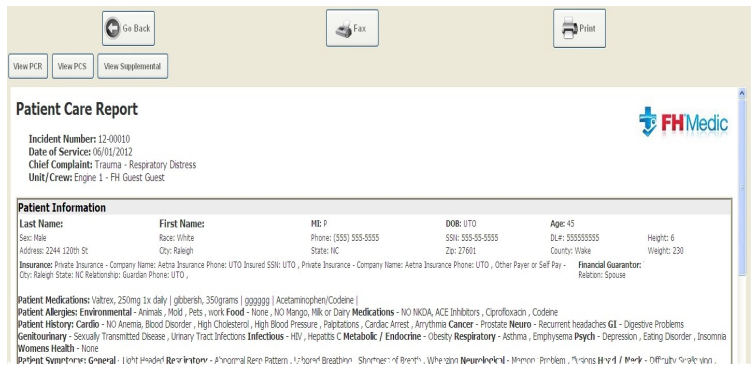
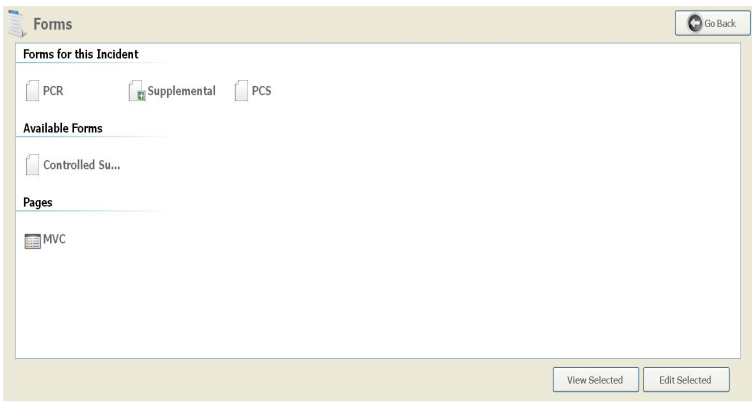
To do this	Do this
	f. Click OK .
Print the PCR	a. In the upper right corner of the interface, click Print . A standard Print dialog box appears. b. Make selections in the dialog box as normal, and then click Print .

The PCR, and any supplemental forms you filled in, are sent to the printer or fax machine for transmission.

3. In the upper left corner of the interface, click **Go Back** to return to working in FH Medic.

View, fax, or print supplemental forms

- Depending on where you are in the FH Medic interface, do one of the following.

If you are here	Do this
At Incidents screen	<p>a. At the bottom of the interface, click View PCR.</p>  <p>The Patient Care Report screen appears.</p>  <p>b. In the upper left corner of the interface, click View Supplemental.</p>
At any screen except the Incidents screen	<p>a. Choose FH → Incident → Forms.</p> <p>The Forms screen appears.</p>  <p>b. Under Forms for this Incident, click Supplemental.</p> <p>c. In the lower right corner of the interface, click View Selected.</p>

Any supplemental information you added to patient care report, such as injury markers on a human body diagram, vehicle crash data, automatic narrative, and so forth, appears.

Go Back

Fax

Print

View PCR

View Supplemental

Supplemental Form

Incident Number:

Date of Service:

Unit: Medic 1

Patient Last Name:

Chief Complaint:

Crew: 2

Injuries

1: Front Left Upper Leg: Gunshot

2: Front Head: Fall Fracture

3: Front Head: Fall Laceration

4: Front Head: Fall Hemorrhage

5: Front Head: Fall Swelling

6: Left Chest: Fall Fracture

7: Left Chest: Fall Swelling

8: Front Left Knee: Fall Contusion

9: Front Left Knee: Fall Abrasion

10: Front Left Foot: Fall Tenderness

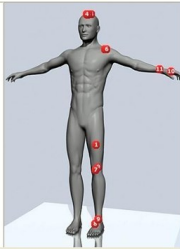
11: Front Left Foot: Fall Dislocation

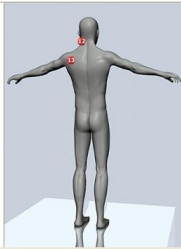
12: Front Left Hand: Burns 2nd Degree

13: Front Left Lower Arm: Burns 2nd Degree

14: Back Neck: Fall Contusion

15: Left Upper Back: Fall Contusion

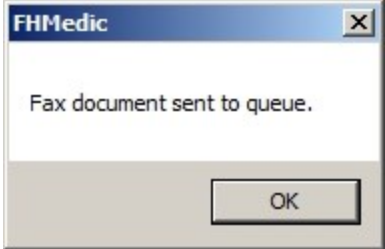




Auto Narrative

2. (Optional) Do any of the following.

To do this	Do this
Fax the supplemental forms to a person or facility	<div><div>a. In the center of the top of the interface, click Fax.</div><div>The No Destination Specified - enter fax number dialog box appears.</div><div><div>No Destination Specified - enter fax number</div><div><div><div></div></div><div><div>Send Fax</div><div>Cancel</div></div><div><div>Choose Other Location</div></div></div></div><div><div>b. Click Choose Other Location.</div><div>The Select Location dialog box appears. If any fax numbers are already defined in FH Medic, a list of them appears in the dialog box.</div><div><div>Select Location...</div><div><div>Rex Hospital</div><div>Wake Medical Center</div><div>Wake Med Apex</div><div>Wake Med Cary</div><div>Cancel</div></div></div></div></div>






To do this	Do this
	<p>c. (If the fax number you need is listed) Click the pre-defined fax number.</p> <p>d. (If the fax number you need is not listed) In the blank field, type the number of the fax machine to send the supplemental forms to.</p> <p>e. Click Send Fax.</p> <p>A confirmation message dialog box appears.</p>  <p>f. Click OK.</p>
Print the supplemental forms	<p>a. In the upper right corner of the interface, click Print.</p> <p>A standard Print dialog box appears.</p> <p>b. Make selections in the dialog box as normal, and then click Print.</p>

The supplemental forms you filled in are sent to the printer or fax machine for transmission.

3. In the upper left corner of the interface, click **Go Back** to return to working in FH Medic.

View or print a Physician Certification Statement (PCS)

- Depending on where you are in the FH Medic interface, do one of the following.

If you are here	Do this
At Incidents screen	<p>a. At the bottom of the interface, click View PCR.</p>  <p>The Patient Care Report screen appears.</p>  <p>b. In the upper left corner of the interface, click View PCS.</p>
At any screen except the Incidents screen	<p>a. Choose FH → Incident → Forms. The Forms screen appears.</p>  <p>b. Under Forms for this Incident, click PCS.</p> <p>c. In the lower right corner of the interface, click View Selected.</p>
On any data entry tab	<p>a. In the upper right corner of the interface, click View PCR.</p>  <p>The Patient Care Report screen appears.</p>  <p>b. In the upper left corner of the interface, click View PCS.</p>

A Physician Certification Statement appears, generated from the information you have entered when you attached a PCS form to the patient's insurance information.

Physician Certification Statement

FH Medic

Medicare covers non-emergency ambulance transportation only if the patient's medical condition is such that other means of transportation are contraindicated. Non-emergency ambulance transportation is appropriate if either: the beneficiary is bed-confined and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or, if the medical condition is such that transportation by ambulance is medically required. Medicare defines bed confined as: "The inability to get up from bed without assistance and the inability to ambulate and the inability to sit in a chair or wheelchair."

Patient Name:	Charles Torres	Date of PCS Certification:	10/25/2012 2:06:11 PM
Date of Birth:	UTO	Medicare Number:	

Medical Necessity Information: Please select the condition(s)/ service(s) which requires ambulance transport:

EKG monitoring required enroute	Yes	Suctioning required enroute	Yes
Ventilator dependent, apnea monitor	Yes	Oxygen required (not applicable to prescribed O2 as a self-administered therapy)	Yes
Possible intubation needed or deep Suctioning	Yes	Restraints: Danger to self or others	No
IV monitoring or IV medications required	Yes	Transport to facility for treatment	No
Is patient being self-administered	No	Transport to facility for treatment	No



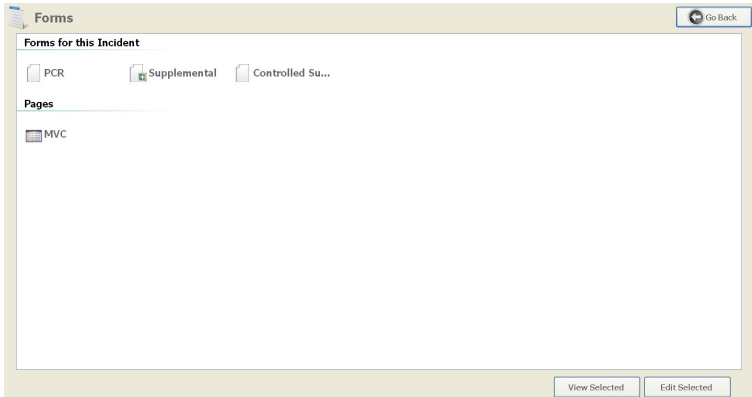
Information on attaching a PCS form is available in [Attach a Physician's Certification Statement \(PCS\) form](#), on page 47.

2. (Optional) Print the PCS
 - a. In the upper right corner of the interface, click **Print**.
A standard **Print** dialog box appears.
 - b. Make selections in the dialog box as normal, and then click **Print**.
3. In the upper left corner of the interface, click **Go Back** to return to working in FH Medic.

View, fax, or print the Controlled Substance Usage / Waste form

Note: To view, fax, or print this form, you must have already added it to the incident, as described in [Add forms to the incident](#), on page 128.

- Depending on where you are in the FH Medic interface, do one of the following.

If you are here	Do this
At Incidents screen	<p>a. At the bottom of the interface, click View PCR.</p>  <p>The Patient Care Report screen appears.</p>  <p>b. In the upper left corner of the interface, click View Narcotic.</p>
At any screen except the Incidents screen	<p>a. Choose FH → Incident → Forms.</p> <p>The Forms screen appears.</p>  <p>b. Under Forms for this Incident, click Controlled Substance.</p> <p>c. In the lower right corner of the interface, click View Selected.</p>

Any controlled substance usage or waste information you added to the incident appears.

Controlled Substance Usage\Wastage

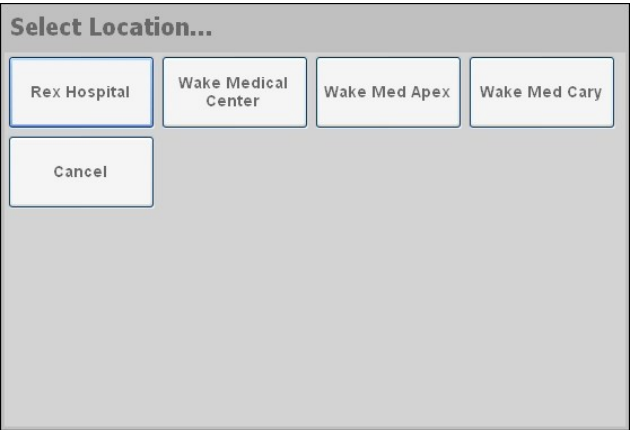
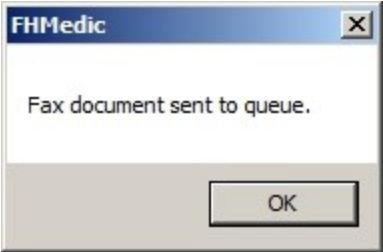
Patient Name		Incident #	
Date of Service	Time	Unit #	

Medication Administered	Amount Used	Unit	Amount Wasted	Unit	Witnessed Usage	Witnessed Wastage

Reason for Use: Standing: PARAMEDIC SIGNATURE: _____

2. (Optional) Do any of the following.

To do this	Do this
Fax the controlled substance usage/wastage form to a person or facility	<p>a. In the center of the top of the interface, click Fax.</p> <p>The No Destination Specified - enter fax number dialog box appears.</p> <p>b. Click Choose Other Location.</p> <p>The Select Location dialog box appears. If any fax numbers are already defined in FH Medic, a list of them appears in the dialog box.</p>

To do this	Do this
	<div data-bbox="743 268 1369 695">  </div> <p data-bbox="641 722 1421 961"> c. (If the fax number you need is listed) Click the pre-defined fax number. d. (If the fax number you need is not listed) In the blank field, type the number of the fax machine to send the supplemental forms to. e. Click Send Fax. A confirmation message dialog box appears. </p> <div data-bbox="865 976 1245 1226">  </div> <p data-bbox="641 1253 792 1281">f. Click OK.</p>
Print the controlled substance usage/wastage form	<p data-bbox="641 1304 1263 1375">a. In the upper right corner of the interface, click Print. A standard Print dialog box appears.</p> <p data-bbox="641 1396 1421 1423">b. Make selections in the dialog box as normal, and then click Print.</p>

The supplemental forms you filled in are sent to the printer or fax machine for transmission.

3. In the upper left corner of the interface, click **Go Back** to return to working in FH Medic.

Attach files to or delete files attached to an incident

1. Choose **FH** → **Incidents** → **Attachments**.

The **Attach Files to** screen appears.

Attach Files to

File Name	Time Added
-----------	------------

Back Delete Selected Add File

Note: Maximum file size for each attachment is 1.5 MB

2. Click **Add File**.
A file browser appears.
3. Use the file browser to navigate to and select the file to attach to the incident.
The file is added to the list on the **Attach Files to** screen.
4. (Optional) Select the file you want to delete, and then click **Delete Selected**.
The file disappears from the list, and is no longer attached to the incident.

View the procedure for treating a symptom

1. Choose **FH** → **Incidents** → **Protocols**.

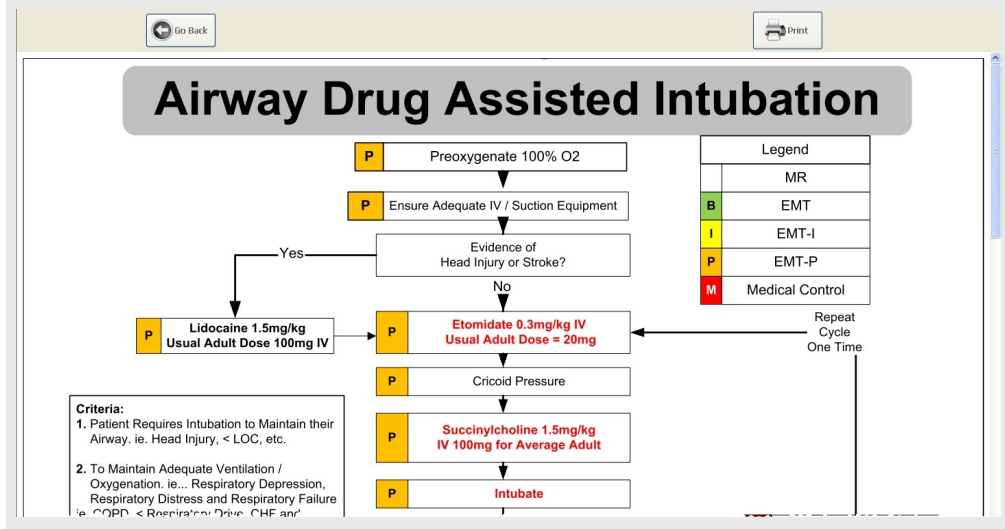
A list of symptoms appears.



2. Click the symptom you want to see procedural steps for.

A screen showing a flowchart, diagram, or series of steps appears, depending on the established protocol for treating the symptom you selected.

Example: If you click **Airway Drug Assisted Intubation**, the **Airway Drug Assisted Intubation** screen appears, containing a flowchart of steps, questions, medication to administer.



3. (Optional) Print the protocol.
 - a. In the upper right corner of the interface, click **Print**.
A standard **Print** dialog box appears.
 - b. Make selections in the dialog box as normal, and then click **Print**.
4. In the upper left corner of the interface, click **Go Back** to return to the list of symptoms.

View installation and synchronization information

You can view information about your FH Medic installation and discover at a glance whether or not the mobile computer is sending data to the FH Medic Cloud as expected.

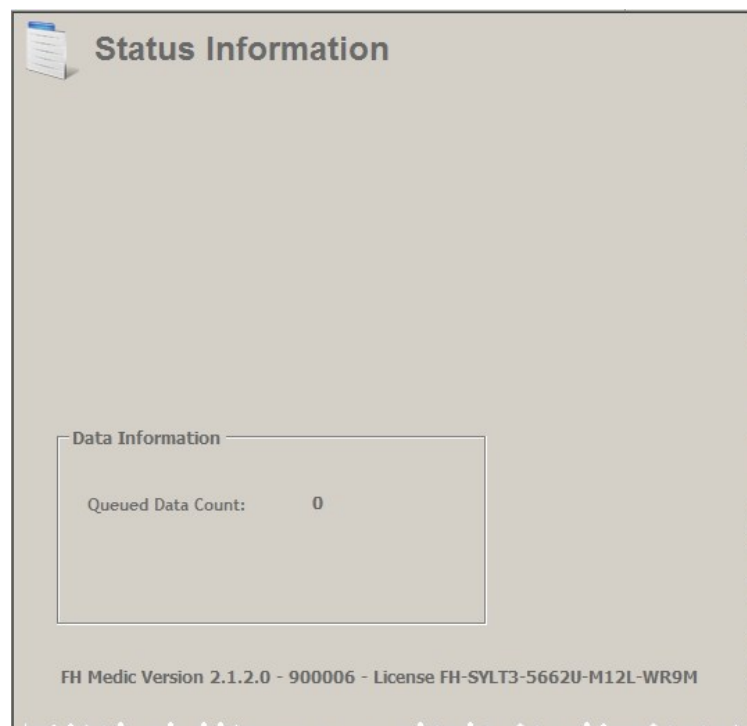
1. In the upper left corner of the interface, click the **FH** logo.

A menu appears.



2. Choose **FH** → **Info**.

The **Status Information** screen appears, listing information about your FH Medic installation. The value in the **Queued Data Count** field indicates whether there is data on the mobile computer that has not yet synchronized with the FH Medic Cloud, which can indicate whether or not the computer has an active Internet connection.



3. (Optional) On the far right side of the screen, click **Refresh** to update the information displayed on the page.

Minimize or exit FH Medic

1. In the upper left corner of the interface, click the **FH** logo.
A menu appears.



2. Depending on what you want to do, do one of the following.

To do this	Do this
Leave FH Medic running, but minimized	<ul style="list-style-type: none">• Choose Minimize. FH Medic continues running, but is minimized and no longer appears on your working screen. An icon for FH Medic appears in your status bar, and you can click the icon to return FH Medic to normal use.
Exit FH Medic	<ul style="list-style-type: none">• Choose Exit. FH Medic closes completely. <div>Note: Because FH Medic automatically relays your data to the server using a wireless connection as you work, you do not need to save data before exiting.</div> <div>Caution: Be sure to exit FH Medic before shutting down or restarting your computer.</div>